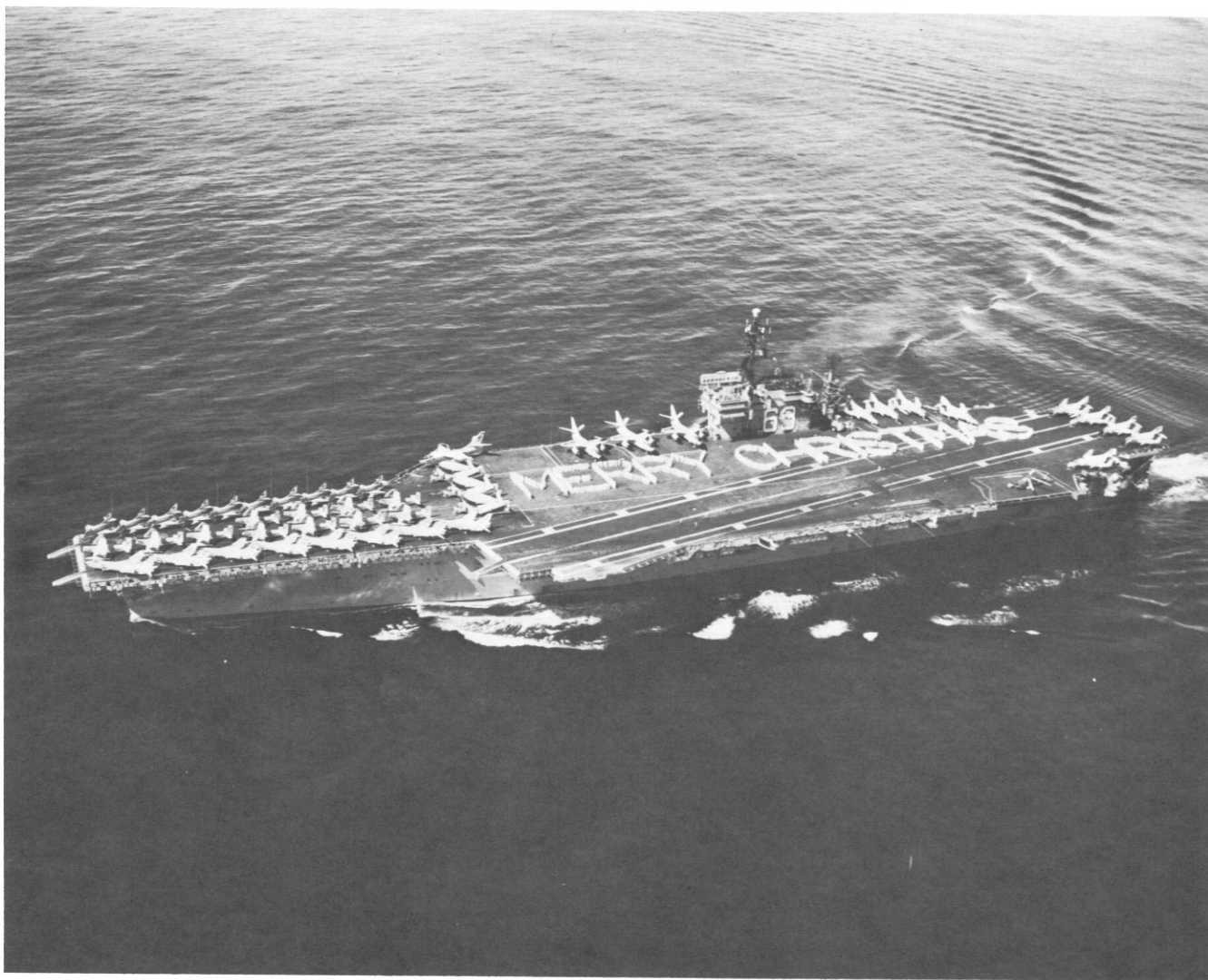




**U. S.  
NAVY**

# **Medicine**

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December 1973

## UNITED STATES NAVY MEDICINE

Vol. 62

December 1973

No. 6

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NAVMED P-5088

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**Credits:** All pictures are Official U.S. Navy Photographs unless otherwise indicated.

Our front cover photo, for which we are indebted to The Naval Photographic Center at Naval Station Washington, D.C., reveals a timely arrangement of the ship's crew on the flight deck of USS *Kitty Hawk* (CVA-63). Though the picture was taken in 1963, the message remains valid today. Have a good one, everybody.

The photo on page 2 was taken at U.S. Nav Hosp Guam, M.I., in July 1973, when the Surgeon General, VADM D.L. Custis, MC, USN (2nd from the right), and CAPT E.B. McMahon, MC, USN (3rd from the right), BUMED Code 31, visited the staff at the Naval Hospital.

The continued support of the Illustrations and Exhibits, and the Photography Divisions of the Media Department, Naval Medical Training Institute, NNMC, Bethesda, Md., is gratefully acknowledged.



# from the Chief

All of us in one way or another are vitally concerned with the future of Navy Medicine. My own preoccupation with it is total, and I believe a key element in our future is our expanding role in medical education.

\* \* \* \* \*

There are some fascinating aspects about our future. Consider for example this irony. Congress, under recent legislation, has not only expanded our volume responsibility for post-doctoral medical training, but added undergraduate involvement as well. Yet other government agencies are simultaneously bent on rendering us incapable of any academic endeavor.

Certain analysts and social planners in Washington, D.C. have repeatedly opined that military medical care should be restricted to the active-duty patient, to the exclusion of the retired and dependent. Military medical support for dependents and retired is, they say, discriminatory against this new inherent right of the civilian patient, and should therefore be transferred to a civilian health-care system of some yet-to-be defined format.

\* \* \* \* \*

Anyone who understands medicine at all knows that patient care, medical education, and research form an indispensable triad, the segmental qualities of which are mutually dependent upon each other. However, there are those who not only fail to recognize in military medicine one of the few truly successful comprehensive health-care systems in the country, but are also totally unappreciative that only with a cross sectional clinical load can our system engage in the education, training and research so essential to quality professionalism. Only a professional dreg would sell himself to a military medical organization without academic image, and with none but healthy young personnel for which to care.

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The above excerpts were taken from an address given by VADM Custis, MC, USN at the 8th Annual Marty Macklin Lecture Series, Naval Hospital Portsmouth, Va., on 9 Nov 1973.



Our toehold against such irresponsible onslaught is Public Law 92.426, commonly known as H.R. 2 — a most timely and propitious development. Just one year after its conception, 5000 H.R. 2-scholarships are almost 100% subscribed, and a highly effective Board of Regents is well along with its work.

\* \* \* \* \*

A fascinating development is that every organization which testified against H.R. 2 is now 180° reversed. All have registered their pledge to help. It is apparent the civilian portion of faculty recruitment will present no problem.

\* \* \* \* \*

For emphasis, I would list three things the medical school is not expected to accomplish:

- . It is *not* intended to provide other than a small, steady portion of the physician needs of the Armed Services.
- . It is *not* intended to decrease or downgrade the numerous affiliations and agreements already existing, and continuing to expand between military and civilian facilities.
- . It is *not* believed that the establishment of a military medical university will in itself be the solution to the retention problem existent in the three Services. Our renewal will be dependent upon a whole series of innovations.

\* \* \* \* \*

Anticipating our role in the university organization, the Navy Medical Department serendipitously expects to:

- . Project our own image on the medical academia.
- . Effectively refute the "second-rate" impression ascribed to us by our civilian peers.
- . Participate as an equal in developing health-care programs, and demonstrate the inherent high quality of our system.
- . Provide a rotation base for our academically oriented physicians, and give professional rank to senior talent.
- . Create centers of excellence in training for aerospace, hyperbaric, submarine, amphibious, preventive, and tropical medicine, and many other areas peculiar to the military.
- . Establish an inservice continuum of undergraduate and graduate education, with degree-awarding potential for the whole spectrum of health professionals.

\* \* \* \* \*

These are indeed critical times. But it is also a time to remind ourselves that we are of a durable body, of enduring tradition, able to absorb buffeting and change without losing character and style. It is a time to lift our heads, look around, and realize that our renewal is the more assured.

This brings us to the modern emphasis on process, an emphasis suggested, in its broadest implications, by Arnold Toynbee when he said:

"Time is a movement — And not a condition:  
Time is a voyage and not a harbor."





CRASH ON THE FLIGHT DECK.—Returning from a combat mission with two hung bombs, the A-6A aircraft pictured above crashed aboard *MIDWAY* (CVA-41) on 24 Oct 1972. The *Intruder* skidded up the axial deck sideways, smashing into four other parked aircraft. The A-6A tail section was severed, and the after fuselage burst into flames. (Photo through the courtesy of CDR P.W. Scrimshaw, MSC, USN, BUMED Code 512, Physiology Training Branch.)

# CRASH on the FLIGHT DECK

## A Mass Casualty Narrative

By LCDR Donald A. Vance, MC, USN,  
Flight Surgeon,  
USS MIDWAY (CVA-41),  
FPO, San Francisco, California 96601.

A mass casualty disaster can occur aboard an aircraft carrier with devastating suddenness. On the night of 24 Oct 1972 it happened in the USS *Midway* as the initial call, "Crash on the flight deck" was passed over the 1MC loudspeaker system at 2000 hours. I was in the sick bay with another flight surgeon, when the A-6 aircraft lost a wheel on landing and crashed into parked aircraft on the forward portion of the flight deck. As I immediately started for the flight deck, LT R.C. Hollerich, the other flight surgeon who would serve as primary anesthesia medical officer began organizing the preparation of the operating room with the prompt assistance of LCDR J.H. Wells, general surgeon and senior medical officer.

Because we had drilled for just such an accident, minimal time was lost in starting preparations for mass casualties. Although at the time they had been held we were somewhat less than enthusiastic, we came to bless the drills, for, without doubt this enabled us to provide more rapid care for the 24 seriously injured personnel who were admitted to the ward. The significant reduction in potential loss of life and limb that was attributable to preparedness was evident to those who participated.

Our mass-casualty plan provides for four medical teams: One reports to the immediate scene; A second team sets up initial triage on the hangar bay, sorting the injured for more rapid transfer, in order of precedence, to the third team in the triage and holding area on the after-mess decks; The fourth or operating team consists of the general surgeon, and a flight surgeon for anesthesia support. The operating team prepares the sick bay, located on the third deck just beneath the after-mess-deck triage, for the reception of the severely injured who require the most immediate care. Included among their support personnel are the X-ray, blood bank, and operating-room technicians.

When I arrived on the flight deck, about one minute after the crash and shortly after the sounding of general quarters, one patient was already situated in the flight deck battle-dressing station; his obvious humerus fracture and leg laceration were being attended by two of the flight-deck corpsmen. After a quick check on his status, I proceeded forward just as the crash crew succeeded in controlling the fire that had ensued after the crash. A later assessment revealed that the prompt action of the MB-5 crash crew probably averted a major conflagration, as spilled JP-5 fuel and ordnance were potential hazards in the fire area.

Upon arrival at the number one elevator forward, it was apparent that several casualties had already been collected there by the corpsmen who had assisted in

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The opinions or assertions expressed in the above article are those of the author and do not necessarily reflect the views of the Navy Department or the naval service at large.

pulling the injured out from the accident scene. Assessment of injuries was made very difficult by the necessity of working by flashlight, and the fact that the ship entered a driving-rain squall at about this time. A quick evaluation of each patient was made as they were brought to the elevator-collection point. Two casualties were pronounced dead at that point and these remains were moved aside, to be taken below after the injured personnel had been attended. One attempt at cardiopulmonary resuscitation was made on a patient who developed arrest while on the elevator, unfortunately without success. Another patient who developed respiratory difficulties was the first to be moved below, after a malfunction of the flight-deck elevator forced patient evacuation by an alternate route in a small-weapons elevator. Allowing for room to work around them, the small elevator can hold only two litters. Some delay was thereby required to establish priorities in the movement of patients into the small elevators, for on the large, deck-edge elevator all patients could have been lowered at once to the hangar. In the future the communication difficulty encountered here, under the conditions of darkness, wind, and rain will be alleviated by a contingency plan; the medical officer at the scene will have a "headset" radio available for communications with flight deck and primary

control. It is estimated that all the severely injured were collected on the large elevator, and had begun to move below within ten minutes of the accident.

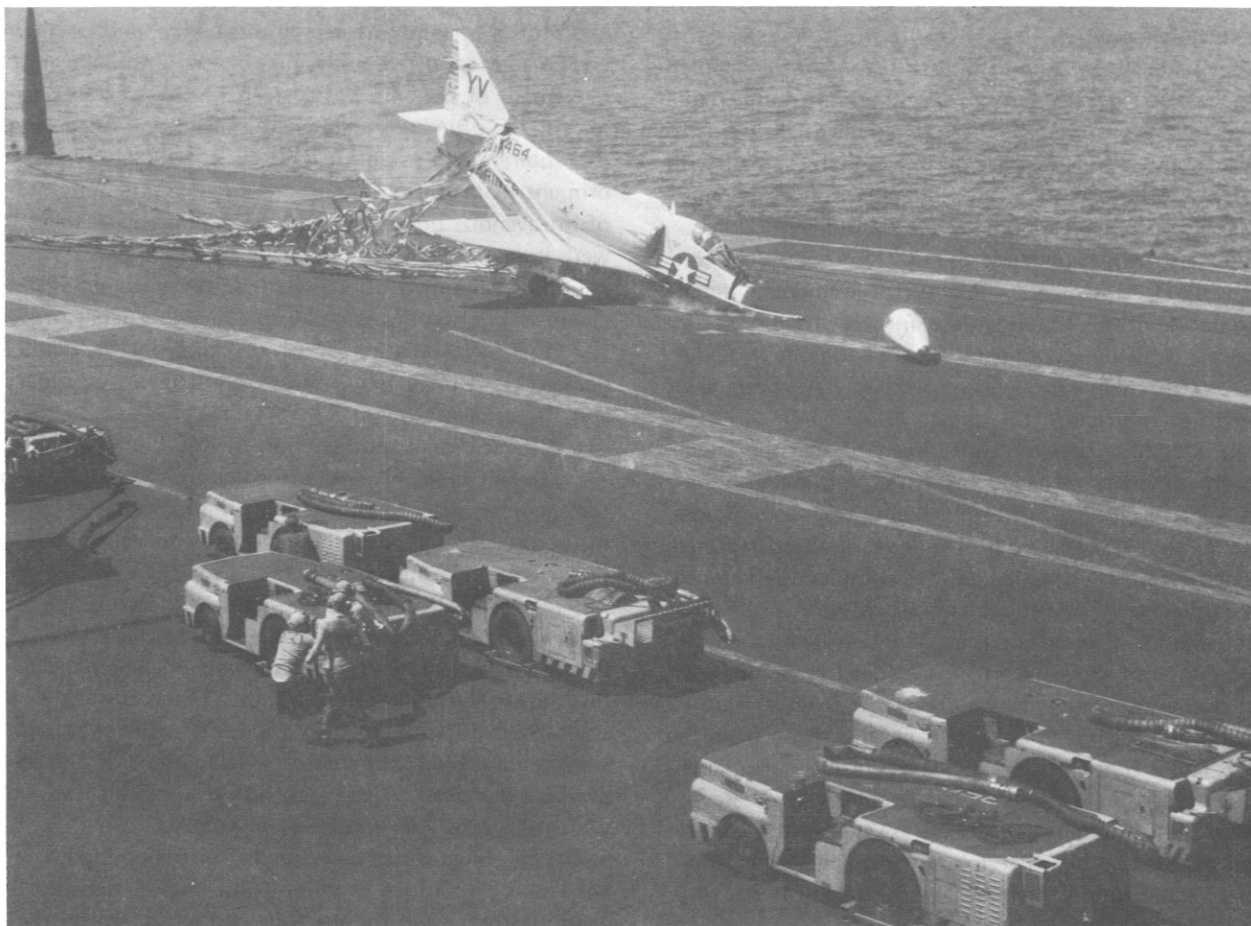
The first patient to arrive below was moved directly into sick-bay treatment room where resuscitation procedures were attempted by the two medical officers stationed there. His respiratory arrest was thought to have resulted from aspiration of JP-5 fuel. Two of the three most seriously injured patients presented open fractures of the lower leg, and the third victim presented an almost-complete BK amputation. The latter patient was later found to have dislocation of the hip, avulsion of the skin overlying the opposite knee, and pelvic fractures.

Tourniquets were appropriately placed in position while the patients were on the flight deck, and the men were expeditiously moved from the flight deck to the hangar bay, then down another weapons elevator which opens onto the after-mess-deck triage area. Once in this area, all the potentially seriously injured received intravenous fluids using angiocaths and Ringer's lactate solution; they were closely monitored for development of shock. It had been decided previously that no narcotics would be given until patients arrived on the mess decks and were evaluated by a medical officer for evidence of shock, head injury, or possible pulmonary



ATTACK AIRCRAFT CARRIER. — USS *Midway* (CVA-41) is pictured underway in the Pacific Ocean. (Courtesy of R.A. Carlisle, Naval Office of Information, Washington, D.C.)





**BARRIER CRASH IN 1965.** — Skyhawk aircraft comes to rest in the barrier after crash landing on the deck of the USS *Midway* due to a hydraulic failure which made it impossible to lower the nose gear or flaps. (Courtesy of R.A. Carlisle, Head, Still Photo Branch, Department of the Navy Office of Information.)

problems. After this evaluation, morphine was administered to the severely injured as indicated; the dosage and time of administration were written on each patient's forehead in ink marking.

As we happened to be short one flight surgeon at the time of the accident, the senior dental officer initially set up the triage area on the after-mess decks and supervised the beginning stabilization of the first patients to be moved below. His assistance was invaluable, and it is strongly recommended that all dental officers participate in the mass-casualty training courses conducted in ships.

The surgeon and flight surgeon were available to assist in the assessment of priorities for emergency surgery, after resuscitative efforts had proved ineffective on the initial patient moved into sick bay. The patient with the most severe leg injury, and who still had a chance for salvage of the limb, was the first patient to be taken to the operating room after X-ray studies had

been done. All the casualties were essentially stable within about three hours after the accident; extremities were properly splinted using Thomas half-ring splints, or plaster, as appropriate. The débridement, irrigation, and stabilization of the first operative case was completed by about 2300 hours. In the operating room, the assistance of a dental officer with anesthesia experience proved most helpful.

As each patient was moved from the treatment room and triage area into X-ray, and then the ward area, other patients were brought down from the mess deck in the order of priorities assigned by the medical officers in the triage area. All medical officers worked in the triage area as time permitted, between X-ray examinations and procedures performed in the treatment or operating rooms.

Movement of patients was a problem that had been previously recognized, as the sick bay is located on the third deck and is accessible only through two hatches



with rather steep ladders. This makes it necessary for all patients to be moved only in Stokes litters, pole litters being unsatisfactory. A minimum number of four men is required to lower a patient down the ladders safely. Once in the sick bay, which is small with narrow passageways, stretchers must still be man-handled through narrow doorways, and over "knee-knockers" which preclude the use of gurney or rolling litters. Drills involving the actual movement of simulated casualties, through triage into X-ray and ward spaces, is highly recommended. We had done this, and the enlightening experience proved to have been well worth the extra effort.

In all, three patients were taken to the operating room. One was managed with straight-spinal anesthesia; One received spinal, supplemented by general anesthesia, and; The last surgical procedure was performed under general anesthesia. Rather complete experience in administering anesthesia is obviously a realistic prerequisite for at least one each of the assigned medical and dental officers. A call for medical assistance was quickly answered by a medical officer from a nearby ship; a flight surgeon and the general surgeon from the USS *Kitty Hawk* arrived at about 2400 hours. The surgeon assisted with the final two operative cases, while the other medical officers assisted in the continued assessment of other injured men, including adequate stabilization for medical evacuation off the ship to shore facilities.

Medevac arrangements were made with the 95th Evacuation Hospital in DaNang, R.V.N., and the 37th ARRS for transportation to DaNang. The Air Force C-9 Nightingale aircraft, for transfer of the most severely injured, was waiting in DaNang by the time the first patients arrived via helo Medevac. No major problems were encountered in the evacuation which was carried out smoothly and promptly, despite a disrupting rocket attack at DaNang during the night. By 0530 hours the most critical patients were situated aboard the C-9, and they arrived at the Clark AFB Hospital for intensive care at 0800 hours. A total time of approximately twelve hours had elapsed. The prompt response and coordination by the 9th Aeromedical Evacuation Unit at Clark AFB was outstanding in all respects, and greatly contributed to the quality of care received by the severely injured casualties.

The value of properly performed drills was reiterated in our evaluation of the events following the accident, and cannot be overemphasized. Injured personnel received first aid rapidly, while still at the accident scene. In the two cases of severe open fractures which approached amputation in degree of severity, the prompt application of tourniquets and splinting of the

extremities certainly decreased morbidity, and possibly even made feasible the salvaging of the limbs. Prompt movement of patients was again held directly responsible for the ultimately decreased morbidity. According to requirements established at drill, supplies were brought from storerooms to ensure adequate amounts of intravenous fluids, angiocaths, and dressings; these were immediately on hand in the triage area.

Other recommendations were addressed in a full-accident debriefing involving all of the ship's departments:

(1) The installation of white lights on the flight-deck-forward for emergency use, controlled by primary and the bridge.

(2) Additional spotlights on the MB-5 crash vehicle.

(3) The radio headset for communication between the medical officer at the scene of the accident (now in use on *Midway*), and the air boss — to coordinate medical and elevator activities.

(4) Installation of skids on the ladders leading down into sick bay (now installed in *Midway*).

(5) Investigation directed toward changing the buckles on the Stokes-litter straps. Those currently in use proved difficult to open, especially when wet, and were responsible for unnecessary delay in making litters available for use. Also, these litters should be stored with the straps loose, instead of fastened.

One problem which developed after the accident was the lack of definitive cause-of-death information; the autopsies requested for the four casualties, whose remains were shipped to Saigon were not performed. Generally the care of the deceased did not present a problem, since the remains were transferred off the ship shortly after the last medevac helicopter left, making long-term storage unnecessary.

Paperwork involving the preparation of patients for medevac, as well as the identification of the deceased, and compilation of lists of the injured casualties, were expeditiously handled by the Medical Service Corps officer and a Personnel officer who was assigned to assist him. These vital functions cannot be neglected and proper forms should be available. In the midst of the mass-casualty situation, medical officers will not have sufficient time to attend to such details. One recommendation in this area is that the wearing of dog tags for identification of person and blood type is essential; this should be emphasized to ship's personnel.

The totals of five dead and 23 seriously injured were regrettable, but could easily have been much higher. With the potential for accident which continually exists aboard attack carriers, or any Naval ships, the only answer to the successful handling of the mass-casualty disaster lies in preparedness that is based on maximum foresight, and the willingness to assist which is

prevalent throughout the fleet. *Midway* was fully operational once more, within five hours of the crash.

Well trained, disciplined, and dedicated personnel made that possible. 🌿

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## UPWARD MOBILITY NURSE TRAINING PROGRAM

Two women were selected by the Chief of Nursing Service, National Naval Medical Center (NNMC), Bethesda, Md., in a pilot program for the Nursing School of Montgomery College at the Takoma Park campus, which began with this fall term. The two candidates, Mrs. Juanita Z. Cossaboon and Mrs. Frances D. Johnson were selected through the competitive procedures of the Merit Promotion Plan, from among 19 licensed practical nurses and nursing assistants at NNMC, Bethesda.

Before completing a course in Practical Nursing at the South Carolina Baptist Hospital, Columbia, S.C., Mrs. Cossaboon worked as an airline stewardess, and a bank-vault custodian and teller. Since then, she has been employed as a licensed practical nurse at Montgomery General Hospital, Olney, Md. She then accepted an appointment as a nursing assistant at NNMC Bethesda, and was later reassigned to the position of Electrocardiograph Technician.

Mrs. Johnson completed a course of study in Practical Nursing at Anna Burdick Vocational School, affiliated with The George Washington University, Washington, D.C., for which she received a Practical Nurse Licensure in the Commonwealth of Virginia. She first was employed as a practical nurse at Providence Hospital, Washington, D.C., and finally as a nursing assistant at NNMC Bethesda.

The basic nursing curriculum covers two full academic years. Upon successful completion of the program, the two nursing assistants will be granted Associate in Arts degrees, and they will be eligible to take the Maryland State Board examination for Registered Nurse Licensure.—PAO, NNMC, Bethesda, Md.



**TWO NURSE-TRAINING PROGRAM SELECTEES.—**Through the Merit Promotion Plan at NNMC, Bethesda, and the Nursing School of Montgomery College, the Chief of the Nursing Service at NNMC has selected Mrs. Frances D. Johnson (left), and Mrs. Juanita Z. Cossaboon (right), for a Registered Nurse-Licensure program. The pilot program is now established for the Nursing School of Montgomery College, at the Tacoma Park, Md., campus. 🌿

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## MINIATURE MEDALS

Uniform Regulations for wearing of miniature medals on formal dress uniforms and Dinner-Dress Blue jackets, heretofore worn on the lapel, will now be worn *on the left breast three inches below the notch, and centered on the breast*. The maximum number of medals to be worn on one row remains eleven, and the maximum length of the holding bar is 4 1/8 inches.—PAO, BUMED Code 1B, Washington, D.C. 🌿

# Primary Herpetic Gingivostomatitis in the Adult

By LCDR Clare A. Emery, Jr., DC, USN,  
Dental Clinic, Building 600,  
Naval Training Center,  
Great Lakes, Illinois 60088.

## INTRODUCTION

Primary herpetic gingivostomatitis most frequently occurs in children under 5 years of age. Frequently those children who are infected with the herpes simplex virus are asymptomatic, or only moderately debilitated. Occasionally, this infection will occur in an adult (approximately 15% of the cases) and can cause severe complications.

## REPORT OF A CASE

A 17-year-old male, beginning recruit training at Great Lakes, Ill., reported to the Naval Training Center dental clinic three days after commencing active duty. He complained of a sore throat, difficulty in swallowing and eating, excessive fatigue, nervousness and apprehension. Past medical history was not unusual.

Clinical examination revealed an oral temperature of 102.5°F, submandibular lymphadenopathy, and lip edema. Crusted, vesicular lesions were present along

the vermillion border of the upper lip (See Figure 1). Intra-orally, multiple vesicular and ulcerated lesions were present along the mucous membrane of the lips, buccal mucosa, oropharynx, palate, and tongue (See Figures 1, 2, and 3). The lesions of the buccal mucosa, oropharynx and palate were surrounded by an erythematous border. The tongue lesions were multiple, raised,



Figure 1

Primary herpetic gingivostomatitis lesions are vesicular and crusted, especially noticeable along the vermillion border of the upper lip.

The opinions or assertions contained herein are those of the author and are not to be construed as official, or necessarily reflecting the views of the Navy Department or the naval service at large.



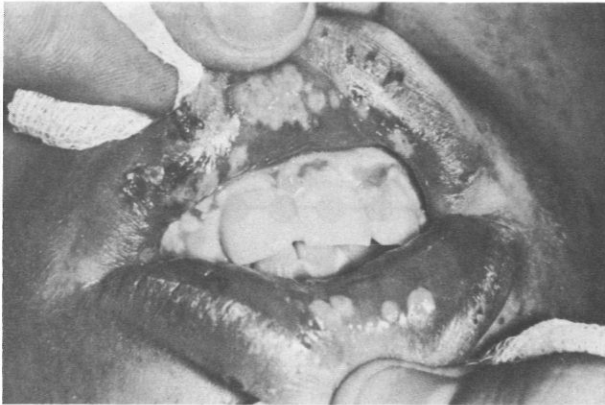


Figure 2

Multiple intra-oral lesions of herpetic gingivostomatitis are present along the mucous membrane of the lips and buccal mucosa.



Figure 3

Multiple vesicular and ulcerated lesions of herpetic gingivostomatitis involve the buccal mucosa, oropharynx, tongue, and palate.

and white. The patient related that he had noticed the lesions growing progressively larger over the past three

days, and his oral pain had similarly worsened. He was also suffering from inflamed tonsils.

A clinical diagnosis of primary herpetic gingivostomatitis was made, and the patient was transferred to the base medical service until his symptoms subsided and healing commenced. Treatment consisted of nutritional support and symptomatic relief, including topical anesthetic medication, a mouthwash containing equal parts of Benadryl Elixir and Kaopectate, and an analgesic. Oral penicillin was prescribed by the medical service for the tonsillitis.

## DISCUSSION

It was apparent that the patient was exhausted and very apprehensive from his first few days of recruit training, with lowered resistance. Upper respiratory-tract infections (tonsillitis), fever, stress, and emotional upsets may exacerbate the disease and seemed to contribute to the development of herpetic gingivostomatitis in this case. Common patient complaints include headache, nausea, malaise, and a sore mouth, followed by the refusal of food. The lesions usually begin to heal in three to five days, and heal completely without scarring in ten days to two weeks.

## CONCLUSION

It is important to reassure the patient that the disease is generally self-limited, brief in duration, and is not disfiguring. Idoxuridine (Stoxil) ophthalmic ointment and solution have been recommended for extra-oral and intra-oral herpetic lesions, respectfully, to shorten the course of the lesions. There is no available single treatment which can be said to be uniformly and significantly effective. ☸

**SENATOR TOURS PENSACOLA.** — U.S. Senator Lawton Chiles (center), toured the Naval Aerospace Medical Institute, Pensacola, Fla., on Oct 16 after visiting the research laboratories and training facilities. CAPT Robert C. McDonough, MC, USN (left), Institute Commanding Officer, and RADM Oscar Gray, Jr., MC, USN (right), Commanding Officer, Naval Aerospace and Regional Medical Center accompanied the Senator on his tour of the military facilities, upon which he had been previously briefed in Washington. — PAO, Naval Aerospace and Regional Medical Center, Pensacola, Fla. ☸



## THE HEMATOLOGISTS' CORNER

### Autoimmune Hemolytic Disease

By LCDR Craig W. Caldwell, MC, USN,

and

CAPT Richard A. Burningham, MC, USN,  
Hematology Branch, Internal Medicine and  
Clinical Investigation Services,  
Naval Hospital Philadelphia, Pa. 19145.

Mediated by one or more mechanisms involving components of the immune system, autoimmune hemolytic disease (AHD) is characterized by an increased rate of destruction of the patient's own red blood cells. The hallmarks of AHD are: a) a decreased red blood cell life span *in vivo*; b) evidence of "autoimmunity" directed against these cells, as manifested by a positive direct antiglobulin reaction (Coombs' test), or red-cell antibodies in the patient's serum, and; c) evidence of increased blood production in response to the hemolytic process.

#### ETIOLOGY

There are two general theories concerning the development of AHD. The first holds that the fundamental change occurs within the red-cell membrane, forming a new antigen, or presenting an intrinsic antigen in an

abnormal way. Another theory would place the abnormality within the immune system itself, with a loss of the capacity for self-recognition. At the present time this controversy is unresolved, and it is conceivable that elements of both theories are valid.

#### RETICULOENDOTHELIAL-SYSTEM MALIGNANCY AND AHD

Of 234 AHD patients studied by Pirofsky,<sup>1</sup> 113 (48%) had associated neoplasia of the reticuloendothelial system (RES). In 31.5%, AHD and RES neoplasia were diagnosed simultaneously. In 61.4%, an initial diagnosis of neoplasia was made before the AHD became manifest; in only 7% was AHD diagnosed *prior* to detection of the neoplasm, with 10-203 months intervening before the RES malignancy became apparent. It was also noted that, in none of these patients with initial AHD, were the presenting symptoms, signs, hematologic data, or serologic findings significant in predicting the eventual development of neoplasia.

The opinions or assertions expressed herein are those of the authors, and are not to be construed as official, or reflecting the views of the Navy Department or the naval service at large.



From these observations Pirofsky proposed that some individuals have a basic defect in the immune apparatus that limits the ability to initiate normal immune responses. This deficiency prevents the establishment of normal immune homeostatic mechanisms, and abnormal cells produced *in vivo*, which would normally be recognized as foreign and then be destroyed, may be permitted to survive because of a malfunctioning immune apparatus. Either permanent mutations or virus modifications could be involved in the creation of such foreign-host cells. This could result in AHD through a graft-versus-host mechanism. A permanent somatic mutation would result in malignancy, while virus modification could lead either to malignancy, or to AHD without malignancy. This postulate suggests that AHD and RES neoplasia both result from the same abnormality, but neither state induces the other.

The above hypothesis would help to clarify many clinical and laboratory observations: 1) AHD and RES neoplasia may occur simultaneously — in random order, or independent of one another; 2) AHD, and some RES neoplasias occurring in the same individual, frequently appear unrelated in clinical activity and response to therapy; 3) Both AHD and RES neoplasia have a high rate of association with other malignancies, and; 4) AHD frequently appears as one part of a diffuse, immunologically mediated, systemic disease, manifesting a high rate of association with other autoimmune-disease states, malignancies, and biologic, false-positive serologic reactions.

### CLASSIFICATION

There are two general classifications of AHD: serologic, and etiologic. The serologic classification consists of the warm-antibody type, in which the antibody is maximally active at 37°C, and the cold type in which the antibody is maximally active at 2-4°C.

The etiologic classification includes the primary or idiopathic form of AHD which makes up 40% of the cases, and secondary AHD which accounts for the remaining 60%. The secondary form of the disease is seen in association with: lymphoproliferative disorders; other malignancies; autoimmune disorders, such as systemic lupus erythematosus; certain infections, such as infectious mononucleosis, mycoplasma, bacterial endocarditis, and pneumonia; inflammatory or granulomatous diseases, such as ulcerative colitis, acute rheumatic fever, acute and chronic liver disease, and sarcoidosis; transfusion reactions, and; in association with drugs, such as penicillin, quinidine, and alpha-methyl dopa.

This disorder is estimated to have an incidence of 1:75,000 people, and may occur at any age. Women seem to be affected more frequently than males, particularly postmenopausal females. A second peak in incidence occurs in the age range in which chronic lymphocytic leukemia is prominent. The course of the disease is extremely variable and the onset is usually insidious. Onset or relapse may be precipitated by a variety of factors such as infection, trauma, surgery, pregnancy, or psychological stress. Hepatomegaly is present in 30-50%, and splenomegaly is found in over 50% of patients. Diffuse adenopathy may be seen occasionally.

Examination of the peripheral-blood smear shows polychromasia due to an elevated reticulocyte count, spherocytosis, red-cell fragmentation, and nucleated red-blood cells. Occasionally erythrophagocytosis by monocytes may be seen, especially in buffy-coat preparations. Bone-marrow aspiration will demonstrate normoblastic erythroid hyperplasia. The survival of the patient's own red cells, and normal donor red cells is decreased.

The *sine qua non* of AHD is a positive direct Coombs' test. Two distinct specificities of the direct-antiglobulin test are found in warm-antibody AHD. IgG is found on the red-cell surface in 15-50% of the cases, and fractions of the complement system (C'3, C'4) are found in from 30% to over 50%. The red cells from about 25% of patients will react with both anti-IgG and anti-complement serum. It is important to remember that the Coombs' serum, which is routinely used will react with complement as well as IgG. The differentiation between patients whose cells react with anti-IgG or with anti-complement serum is important, from the standpoint of hemolytic mechanisms, as well as prognosis. Those who are IgG Coombs' reactors are more likely to experience severe, recurrent, hemolytic episodes. It should also be noted that certain patients who present the clinical features of AHD may have a negative antiglobulin test when the conventional Coombs' test is employed, however, IgG may be detected by employing a test system of greatly enhanced sensitivity.<sup>2</sup>

The majority of warm antibodies are directed against the Rh system. A significant number of these autoantibodies demonstrate nonspecific behavior, in that they react with all of the common, antigenic types of red cells; however, Rh<sub>null</sub> cells will respond with only a very weak reaction. Rh<sub>null</sub> red cells have been shown to have aberrant U antigen, as well as some degree of abnormality of S and s antigens.

With the discovery that the abnormality in Rh<sub>null</sub> red cells was not restricted to antigens of the Rh complex, it was appreciated that a failure to react with these cells does not necessarily imply Rh specificity. Out of 50 cases of warm-type AHD, Marsh, et al.,<sup>3</sup> found three subjects with antibodies of U specificity.

Vos, et al.,<sup>4</sup> studied the serology of autoantibodies recovered from eluate of red cells that were donated by 24 patients with AHD. In 87% of the cases the eluate contained an antibody which reacted with a routine panel of cells. These antibodies were termed "antinormal" antibodies. Forty-six (46%) of the eluates had an antibody which reacted with Rh<sub>null</sub> cells, and these were termed "antinull" antibodies. The antibodies were found singly, or in combination. Six of eight eluates containing a combination of both "antinormal," and "antinull" activity possessed complement components. In contrast, none of 16 eluates with either specific antinormal or antinull activity (but not both) contained complement components. Thus, all red-cell eluates containing complement components, always revealed the presence of both antinormal and antinull activity. The authors hypothesized that the presence of complement, in association with the combination of antinormal and antinull antibodies, is analogous to complement fixation produced by multiple Rh-isoantibodies. In considering these autoantibodies of multiple specificity, the more frequent occurrence of antinormal antibodies suggests that this autoantibody might indicate an early state of autoantibody production. The progressive formation of antinormal, along with antinull which then tends to result in the fixation of complement on the red cells, may well represent a natural progression of the disease to a more advanced state of autoimmunization. This is comparable to a more advanced state of autoimmunization, comparable to the development of Rh isoantibodies where, as a rule, anti-D is more often noted in the early stages of iso-immunization than is anti-CD.

#### MECHANISMS OF RED CELL DESTRUCTION IN AHD

There are basically three mechanisms of red-cell destruction in AHD. Due to antibody coating and subsequent removal of small bits of erythrocyte membrane, the red cell is converted to a rigid spherocyte, or poikilocyte resulting in prompt removal from the circulation. Coating of the red cell by immunoglobulin may enhance cellular interaction by decreasing the zeta-potential, which is the negative surface charge on the red blood cell, and which causes the individual cells to repel one another. This allows the cells to

come close together, with small amounts of membrane in the form of myelin threads, or fragments becoming detached from the membrane surface. Coated red cells may also interact with fixed and free phagocytic cells of the reticuloendothelial system. The receptor sites on the surface of monocytes and phagocytic cells specifically interact with red-cell membrane coated with IgG, particularly IgG<sub>1</sub> and IgG<sub>3</sub>.

In most cases of warm-antibody AHD, red-cell sequestration takes place primarily in the spleen, whereas in cold-antibody AHD, sequestration takes place in the entire reticuloendothelial system. This is probably a function of the degree of injury to the red-cell membrane, rather than specificity of the antibody.

#### COURSE AND PROGNOSIS

The course of AHD is characterized by relapses and remissions. The duration of idiopathic AHD is frequently measured as the number of months or years before recovery or death. Twenty-five percent of patients appear to recover completely. Occasionally the underlying disease will not become apparent, for ten or more years after the diagnosis of, what appeared to be, idiopathic AHD. Phlebitis is a frequent complication of AHD, and the exact etiology is not well understood. Infection is also associated often with AHD. The simultaneous occurrence of AHD and immune thrombocytopenia has been termed Evans' syndrome.

The prognosis of secondary AHD is largely determined by the underlying disease. In the idiopathic form, 10-40% may succumb to the hemolytic process or complications of treatment. Silverstein, et al.,<sup>5</sup> reviewed 117 cases of idiopathic AHD and found a survival of 91% at one year, 76% at five years, and 73% at ten years. The survival rate was not related to age, sex, initial leukocyte count, platelet count, degree of reticulocytosis, initial severity of anemia, nor the presence or absence of splenomegaly. When patients with idiopathic AHD were considered as groups or subgroups, it was noted that the expectation for survival was below that for matched controls. However, the mortality rate of idiopathic AHD was much less than had been previously appreciated. In only two subgroups were borderline significant differences noted. In patients treated with steroids alone, the survival rate at one year was 86.1% while 96.6% was the expected survival rate. The patients with a negative Coombs' test, but with all the other criteria for AHD, had a one-year survival rate that was 7.2% below the expected figure. In this series, nine patients were treated initially with splenectomy, and survived. Data on the 5- and 10-year follow-up of all patients in this

series suggest, but do not prove, that patients treated with splenectomy and steroids have a more favorable prognosis than those treated with steroids alone.

### TREATMENT

In general, the treatment of AHD may be divided into four phases: the search for underlying disease, steroid therapy, splenectomy, and immunosuppression. The search for underlying disease is probably the most important aspect of managing a patient with this disorder, since the effort is generally rewarded in 60% of the patients. Not only should this endeavor be made in the initial evaluation, but it should be continued as long as the patient is followed, since lymphoproliferative disorders have been known to occur up to ten years after the diagnosis of AHD has been established. Another aspect of general management is the concern that transfusion should be avoided if possible, because it usually results in accelerated hemolysis.

Most patients with warm-antibody AHD respond to steroid drugs, and this response tends to be of an all-or-none character. A daily 60-100 mg dose of prednisone is recommended, and should be maintained until the hematocrit level stabilizes. The effect may be quite rapid, occurring in 24-48 hours. Steroids are capable of decreasing the erythrophagocytic action of leukocytes, and may influence the effect of the organ system involved in hemolysis, i.e., decreased activity of the reticuloendothelial system. Some suppression of the abnormal immune response itself may result from long-term treatment. Employing the therapeutic approach herein described, about 75% of patients will stabilize or significantly improve.

If high-dose steroid treatment is required, or, if there is no response splenectomy is advised. Because of the nature of sequestration in warm-type AHD, splenectomy is helpful in over 50% of cases, regardless of the etiology of the disease.

Aside from steroid treatment, radiotherapy, anti-metabolites or alkylating agents may effect immunosuppression. To date, different centers have reported varying results. In a recent review of immunosuppressive therapy, Skinner and Schwartz<sup>6</sup> noted that, despite treatment with steroids and splenectomy the mortality rate in AHD may exceed 50%. In an analysis of 42 cases selected from the literature, all the patients failed to respond to steroid medication; however, 20 of the 42 were said to have improved with another form of immunosuppressive therapy. The present status of induced immunosuppression would seem to be that if steroids and splenectomy fail,

azathioprine, or cyclophosphamide is a reasonable therapeutic modality.

### AHD ASSOCIATED WITH COLD-REACTING ANTIBODIES

In this class of AHD, the antibody activity is generally maximal at a temperature less than 31°C. Very high titers of cold agglutinins may occur in the course of certain diseases, or without any apparent cause, and may be associated with hemolytic anemia when the patient is exposed to cold. This has been termed cold-agglutinin disease (CAD).

Most cases are idiopathic; those which are associated with lymphoproliferative disorders are usually chronic. The acute self-limited form may be symptomatic of a variety of viral infections such as influenza, infectious mononucleosis, or mycoplasma. The peak incidence of this disorder is seen after 50 years of age. In the idiopathic form, large quantities of IgM may be produced.

The clinical symptoms seem to result from interaction of the agglutinin, red blood cells, and complement, in the distal parts of the body where the temperature may drop below 32°C. As a rule, only those patients with a titer above 1:1000 will develop active hemolysis.

Intense autoagglutination occurs on cooling the blood specimen to 4°C, and to a lesser extent at room temperature, depending on the titer. The agglutination is promptly dispersed by rewarming. Cold agglutinins are usually IgM, and are capable of fixing complement and slowly inducing complement lysis *in vitro*. The ability to fix C'3, and C'4, results in a positive direct Coombs' reaction of anti-C' specificity in most patients. The antibody itself is not detectable on the red cells by the anti-globulin method. There is a complex specificity for the I-i antigen system. Virtually all cold agglutinins of the IgM type react with the I antigen, except those that are found in cases of infectious mononucleosis and which react with i.

As mentioned in the discussion of warm-antibody AHD, red-cell sequestration takes place mainly in the spleen, whereas sequestration takes place throughout the entire reticuloendothelial system in CAD, and is probably a function of the degree of membrane injury rather than the specificity of the antibody.<sup>7</sup> This also explains why steroids may be beneficial in CAD, while splenectomy is not particularly effective.

### SUMMARY

AHD is a hemolytic anemia mediated by components of the immune system. The disorder may be



idiopathic or secondary to some underlying disease process, most notably lymphoproliferative disorders and other autoimmune states. The hallmark of the disease is a positive direct Coombs' test. Immunoglobulin coating of the red blood cell shortens its life span, with resultant anemia. It is a disease of insidious onset, and the course is characterized by relapses and remissions.

The preferred clinical management consists of initial treatment with steroid drugs and supportive care, followed by splenectomy if no response to primary treatment is observed. If steroids and splenectomy fail, other immunosuppressive measures may be considered. Probably the most important aspect of patient management is the professional obligation to search for underlying disease, which is found in 60% of the patients. This search should be continued for as long as the patient is followed, since the underlying disorder may not become manifest for many years after the diagnosis of AHD has been established.

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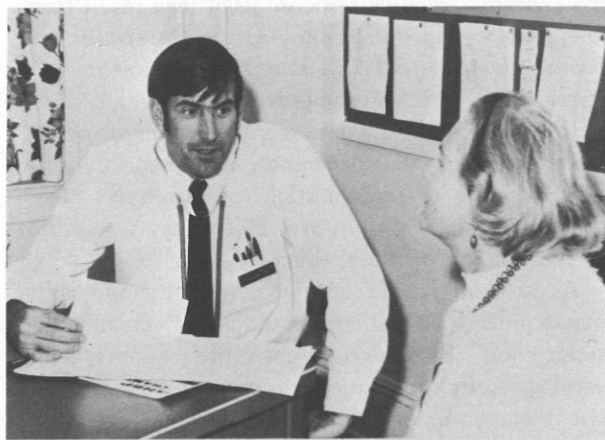
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## SUCCESSFUL PHYSICIAN'S AIDE PROGRAM

In 1971, the Physician's Aide Program was implemented in the General Practice Clinic, Naval Hospital, Newport, R.I., to expedite and personalize care, and to provide a more accurate assessment of the urgency of medical problems. Hospital Corpsman First Class Gerry Gelinas, USN was among the first hospital corpsmen to attend the ten-week training course at National Naval Medical Center, Bethesda, Md., in preparation for this new role. His technical competence, good judgment and sensitive manner have contributed greatly to the success of the program.

The Physician's Aide program has diverted some of the general-practice workload away from the physicians. Needless patient waiting has been reduced or eliminated. Patients are able to utilize waiting time constructively by obtaining appropriate laboratory and X-ray diagnostic tests before consulting the physicians.

In the past two years the role of the Physician's Aide has continually developed and solidified. With the energy and guidance of HM1 Gelinas, the position will undoubtedly continue to mature.



PHYSICIAN'S AIDE.—HM1 Gerry Gelinas, one of the first hospital corpsmen to attend the Physician's Aide Program at NNMC, Bethesda, is shown in action conversing with civilian staff member, Mrs. Julie Hansen.—PAO, Nav Hosp Newport, R.I.

# THE ALCOHOL WITHDRAWAL SYNDROME:

## Diagnosis and Treatment

By LT Glynn A. Bergeron, MC, USNR,  
Alcoholic Rehabilitation Center,  
Naval Regional Medical Center,  
Long Beach, California 90801.

In treating withdrawal from alcohol, the enlightened physician looks for several things in the medical history and physical examination. Such an appraisal aids the clinician in approaching each individual patient, and suggests how aggressive the treatment should be.

- . How much has the patient had to drink? For how long?
- . When was the last time the patient had anything to eat?
- . Is there any history of thyroid dysfunction; diabetes; heart, or other disease?
- . Has the patient had any previous seizures, has he been hallucinating, or does he feel as though he is going into withdrawal?
- . How does the patient look? Is he obese or thin? What are the vital signs? Are there any positive neurological findings?

### CLINICAL ASPECTS

Existing evidence suggests that there is a depletion of magnesium ( $Mg^{++}$ ) with excessive alcohol intake,

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The opinions or assertions contained herein are those of the author, and are not to be construed as official or reflecting the views of the Navy Department, or the naval service at large.

mainly effected through increased urinary excretion.<sup>1</sup> Although controversial, some believe that the use of a 50% solution of  $MgSO_4$  in replacement dosages (2cc intramuscularly Q 4-6H for a total of 6-8 doses) may be useful in replacing Mg stores, thereby reducing the hyperirritability of neural tissue.<sup>2</sup> Theoretically this may be feasible, since hypomagnesemia is regarded by some as a part of the physiologic mechanism of the alcohol-withdrawal syndrome.<sup>3</sup>

In general, detoxification takes an average of three days. It may take longer in some cases, depending upon the severity of the withdrawal. With its onset as early as six to eight hours after abstinence, the minor withdrawal usually consists of tremor, mild diaphoresis, and tachycardia. However, this may be accompanied by hallucinations (auditory and visual), and/or convulsions, and/or minimal disorientation. These manifestations will usually occur within the first 48 hours. The hallucinations that occur can usually be described by the patient, who will remember them even after the acute withdrawal is over; the hallucinations that occur in delirium tremens, however, are only partially remembered at best, or the patient may have total amnesia for what has transpired.

The onset of major withdrawal or delirium tremens



is usually 60-72 hours after abstinence; approximately one-third of these will be preceded by convulsions.<sup>3</sup> Typically, in delirium tremens there are no convulsions. Characteristic symptoms include: profound disorientation, compounded by a disorder of perception; increased autonomic activity — fever, tachycardia, profuse diaphoresis, and; marked increase in psychomotor activity — tremor, restlessness, vivid hallucinations. The duration is generally less than 72 hours,<sup>4</sup> but can vary. The mortality rate in untreated cases is approximately 15%. It is considered by some authorities that this figure can be reduced to less than 5%, with proper treatment.<sup>5</sup>

### GENERAL APPROACH

Generally, withdrawal patients do not require intravenous fluids; they usually present overhydration, rather than dehydration.<sup>6,7</sup> In selected cases, however, where severe vomiting or delirium tremens (DTs) may be associated with considerable fluid loss through diaphoresis, administration of intravenous fluids may be required.

While considerable controversy surrounds the choice of therapeutic agent for treatment of the withdrawal phase, chlordiazepoxide (Librium) is favored in most of the medical literature. A recent study<sup>8</sup> in which Librium, chlorpromazine hydrochloride (Thorazine), thiamine, hydroxyzine hydrochloride (Vistaril), and a placebo were compared, revealed that Librium proved best in preventing DTs and convulsions. By aggressive management of withdrawal, without over-sedating the patient, the clinician may avert formidable complications such as convulsions and delirium tremens.

Thorazine is not usually desirable because of hypotensive effects, and because it lowers the seizure threshold. In view of potential problems with cross-addiction and cross-tolerance, the use of barbiturates is not recommended. In seizure disorders, however, the therapeutic use of phenobarbital and diphenylhydantoin (Dilantin) may be required. Diazepam (Valium), up to 10 mg per dose may be given slowly as an intravenous injection, to abort convulsions. Withdrawal may be further complicated by hypoglycemia; studies have demonstrated that alcohol can induce hypoglycemia in patients of normal or thin habitus after starvation for three days. Obese individuals are apparently more refractory, and patients with insulin-controlled diabetes, thyrotoxicosis, or an endocrine deficit such as Addison's disease are more susceptible to hypoglycemia effects.<sup>9</sup> Accordingly, if hypoglycemia is presented, initial treatment may include the intravenous administration of 50% glucose solution.

### TREATMENT PROTOCOL

The following protocol is suggested for treatment of withdrawal:

- 1) Medication without over-sedation.
- 2) High-protein diet, with fruit juices (except tomato juice) *post cibum* (PC) and *hora somni* (HS).
- 3) Multivitamins, one tablet *per os* (PO), twice a day (BID).
- \*4) Thiamine, 50 mg PO, four times a day (QID).
- 5) Aluminum hydroxide gel-magnesium hydroxide antacid (Mylanta), 30cc PC and HS, *pro re nata* (PRN).
- 6) Trimethobenzamide hydrochloride (Tigan) suppository, every four hours (Q4H) PRN, for nausea.
- \*\*7) Chlordiazepoxide (Librium), 25 mg PO, Q2-4H, PRN for agitation compatible with withdrawal.
- 8) Chloral hydrate, 500 mg PO, PRN HS. May repeat dose once, after one hour. (Use only during the first two days.)
- \*\*\*9) Diphenylhydantoin (Dilantin), 100 mg QID for five days, then BID for five days.
- 10) Phenobarbital 1/2 grain (gr) PO, three times a day (TID).
- 11) Lab tests: Sequential Multiple Analysis (SMA) 12/60. Complete blood count (CBC), urinalysis, blood-alcohol determination as indicated, electrocardiogram (EKG) if age 35 years or older, and chest X-ray exam.
- 12) Vital signs Q2H while awake — at least QID.

\*Thiamine 100 mg should be given immediately (STAT), intramuscularly, if confusion and nystagmus are thought to reflect the presence of Wernicke-Korsakoff's syndrome; the patient should then be placed on the suggested regimen.

\*\*The usual starting dose of Librium is 25-100 mg Q2-4H. From that point, the dose should be increased or tapered, as necessary. As a rule, the patient should receive a good sedating dose initially and then the medication should be tapered off, but the interval should remain the same in order to provide a smooth course. After the first two days the dose can usually be rapidly reduced, and by the end of the third day the drug can often be discontinued. The initial dose may be administered intramuscularly, but thereafter premuscular or parenteral routes may be employed.

For frank or impending delirium tremens, 200-300 mg Librium per 24 hours has proven very effective in controlling the withdrawal.<sup>8</sup> Ordinarily not more than 300 mg of Librium should be given in a 24-hour period. To reduce the risk of death, adequate fluid and electrolyte balance, and treatment of any associated serious disease is of paramount importance.

\*\*\*This is the suggested regimen for Dilantin and phenobarbital maintenance in patients who present: seizures during withdrawal, or a history of seizures during previous withdrawal, or a documented seizure disorder. The dosage and duration of maintenance should be adjusted as appropriate. Alcohol withdrawal seizures *per se* do not require long-term maintenance.

- 13) Acetaminophen (Tylenol), one or two tablets PO, Q4-6H PRN for headache.
- 14) Notify physician of any decompensation of vital signs.

### DISCUSSION

Besides sedation, the following aspects of treatment must be addressed: fluid and electrolyte balance; carbohydrate metabolism, and; associated injury or infection, especially cerebral laceration, subdural hematoma, or pneumonia.

Because of the delayed onset of delirium tremens, patients may be symptom-free for a period; hospitalization should therefore be continued for at least three days, and preferably five to seven days.

In the treatment of withdrawal, Simpson, and others<sup>10</sup> have suggested that a hostile and negative therapeutic environment will enhance the severity of the withdrawal symptoms, and that negative attitudes should be discouraged. The tone of environmental approach to treatment should be analogous to that of the recovery-room patient. The only difference is that the anesthesia has resulted from alcohol, instead of the usual anesthetic agents.

### CONCLUSION

Some of the current therapeutic concepts of alcohol withdrawal have been presented, as well as suggested guidelines to regulate treatment. Withdrawal from narcotics is not characteristically lethal, whereas withdrawal from alcohol is potentially a life-threatening situation. By early diagnosis and prompt institution of aggressive treatment, the clinician can do much to prevent the lethal complications of this illness.

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SANTA FOR SHIPPING OVER. — Chief Hospital Corpsman Patrick L. Baumert, USN (right) shipped over in Dec 1972 at the Pensacola Naval Air Station Branch Dispensary. At the conclusion of reenlistment ceremonies, Santa presented the Navy Veteran from Oklahoma with a candy cane as an auxiliary reenlistment bonus. — PAO, Nav Aerospace Reg Med Center, Pensacola, Fla.

# COMMAND CHANGES

## NAVSUBMEDRSCHLAB

CDR Raymond L. Sphar, MC, USN relieved CAPT John H. Baker, MC, USN as Officer-in-Charge of the Naval Submarine Medical Research Laboratory, Naval Submarine Medical Center in Groton, Conn., on 1 Jun 1973.

CAPT Baker assumed the directorship of the Submarine and Radiation Medicine Division at the Bureau of Medicine and Surgery (BUMED, Code 74). Included among the mementoes and tributes expressed at the farewell party in honor of CAPT and Mrs. Baker, was a plaque from the Athletic Association of a local high school, for services rendered by CAPT Baker to the football and soccer teams. During his stay at the Submarine Medical Center, the Captain had also served in two other capacities: Director of the School of Submarine Medicine (Apr 1969-Jun 1971); and Director of the Submarine Medical Center Hospital (Jun 1971-Jul 1972).

CDR Sphar was the first U.S. exchange officer in submarine medicine and served in that capacity with

the Royal Navy in 1967-1968. After being awarded the Master of Public Health degree at Yale University School of Medicine in Jun 1972, CDR Sphar served as Assistant Officer-in-Charge at the Naval Submarine Medical Research Lab, Apr 1972-1 Jun 1973.

## MEDICAL/DENTAL DISPENSARY, NAB CORONADO

On 20 Jun 1973 a ribbon-cutting ceremony was conducted at the opening of the Navy Regional Medical Center Dispensary, Naval Amphibious Base (NAB), Coronado, Calif.

Among distinguished participants in the formal opening were: VADM R.S. Salzer, USN, Commander Amphibious Force, U.S. Pacific Fleet; RADM H.G. Stoecklein, MC, USN, CO Naval Regional Medical Center, San Diego; RADM A.K. Kaires, DC, USN, Director, Dental Activities 11TH Naval District, who delivered the dedicatory address; and CAPT R.B. Perez, USN, CO, NAB, Coronado.



**RIBBON CUTTING AT CORONADO.**—At NAB Coronado, Calif., official opening of the Navy Regional Medical Center Dispensary was observed by (from left to right): VADM R.S. Salzer, USN; RADM A.K. Kaires, DC, USN; and RADM H.G. Stoecklein, MC, USN. CAPT R.B. Perez, USN, is the CO, NAB Coronado.



## NAVAL DENTAL CLINIC WASHINGTON, D.C.

On 26 Jun 1973 CAPT Stewart T. Elder, DC, USN relieved CAPT Ralph H. Stowell, DC, USN as CO, Naval Dental Clinic Washington, D.C. CAPT Stowell joined the staff at the Naval Training Center, Orlando, Fla., as Director of Dental Activities.

Former XO at the Naval Dental Clinic, CAPT Elder earned his degree in dentistry at Ohio State University in 1945, and since that time he has seen active naval service in Europe, Korea, and Vietnam.



**CHANGE OF COMMAND.**—CAPT Ralph H. Stowell, DC, USN (left) is relieved by CAPT Stewart T. Elder, DC, USN (right) as CO, Naval Dental Clinic, Washington, D.C.

## NAVAL REGIONAL DENTAL CENTER NORFOLK

On 1 Jul 1973 the first Regional Dental Center in Naval history was established at Norfolk, Va. Under this new concept, 13 dental facilities in the Tidewater-area, Va., came under the command of the first Commanding Officer, Naval Regional Dental Center Norfolk. The first Commanding Officer is RADM V.L. Anderson, DC, USN.



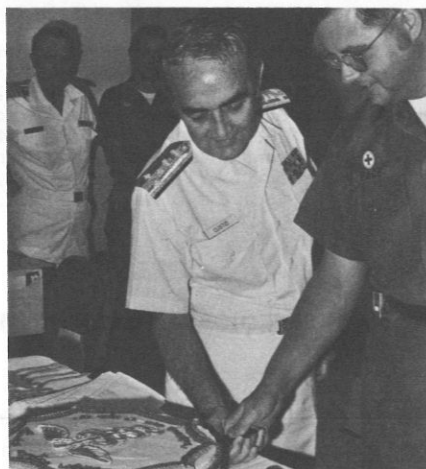
**NAVY DENTAL CORPS MILESTONE.**—On 1 Jul 1973 the first Regional Dental Center in the Navy's history was established in Norfolk, Va. RADM J.P. Arthur, DC, USN (right), former Assistant Chief for Dentistry and Chief, Dental Division, BUMED presented the establishment authorization to RADM V.L. Anderson, DC, USN, the first CO, Naval Regional Dental Center Norfolk.

## NEW CAMP COVINGTON DISPENSARY, GUAM, M.I.

In the first permanent Seabee Camp on Guam, U.S. Naval Mobile Construction Battalion ONE (NMCB-1), a new Camp Dispensary was dedicated on 19 Jul 1973 by VADM D.L. Custis, MC, USN, Surgeon General.

The medical team consists of eight hospital corpsmen, under the direct supervision of LT Frederick J. Doherty, MC, USNR; an independent-duty corpsman also stands by, 24 hours a day. The Dispensary team is qualified in diverse fields, such as environmental and preventive medicine techniques; X-ray and laboratory, and medical-services technology. They are especially concerned with accidents common to the construction field, and prevention and safety programs.

The new 98.9 x 20 ft. building is equipped with an emergency room, treatment room, pharmacy, X-ray area, laboratory and physical therapy spaces, as well as suitable accommodation for supplies, offices, and environmental/preventive medicine.



**NEW RATE AND NEW DISPENSARY.**—VADM Donald L. Custis, Surgeon General of the U.S. Navy, and newly promoted HM1 J. Ronald Pace (right) shared the honors in cutting the cake at the dedication of the Camp Covington Dispensary on Guam, M.I.

## NAVAL REGIONAL MEDICAL CLINIC WASHINGTON, D.C.

On 23 Jul 1973 CAPT Rodger F. Schindele, MSC, USN became the first MSC officer in history to command a Navy medical-treatment facility, relieving CAPT Charles M. Garland, Jr., MC, USN as CO, Naval Regional Medical Clinic Washington, D.C. CAPT Garland subsequently assumed command of the Naval Hospital in USS *Sanctuary*.

Known for over 50 years as The Naval Dispensary, the clinic became the Naval Regional Medical Clinic in 1971 and now claims 11 branch facilities in three states, and the District of Columbia.

As the 20th CO, CAPT Schindele is the first MSC officer to assume responsibility for the Regional Medical Clinic, in keeping with the trend to reassign some command and administrative functions of Medical and Dental Corps officers to Medical Service Corps officers.



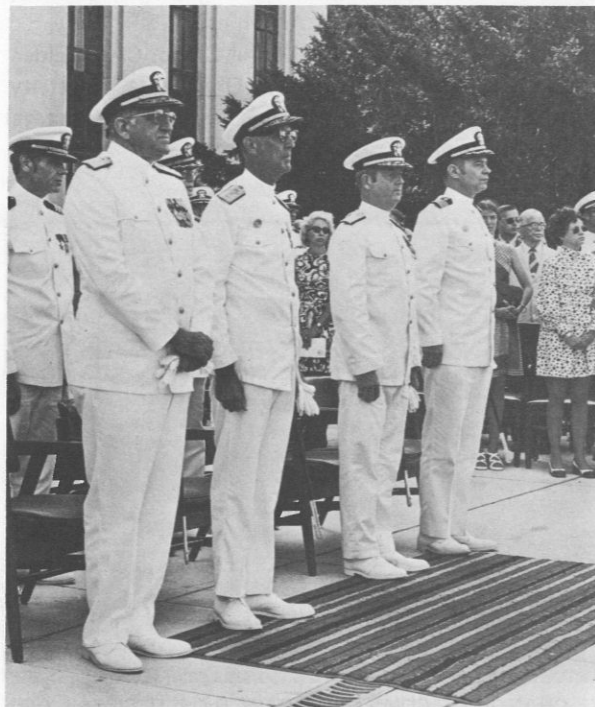
**DOUBLE THE PLEASURE.**—Representing the Surgeon General at the change-of-command ceremony, RADM D. Osborne, MC, USN (left), Assistant Chief for Personnel and Professional Operations, BUMED, presented the Meritorious Service Medal to CAPT R.F. Schindele, MSC, USN (right), the first MSC officer to command a Naval medical-treatment facility. CAPT Schindele relieved CAPT C.M. Garland, MC, USN as CO, Naval Regional Medical Clinic, Washington, D.C.

## NATIONAL NAVAL MEDICAL CENTER (NNMC), BETHESDA, MD.

With color guard and the Navy Band in full array, a formal change-of-command ceremony was held in front of the tower (Building 1) at NNMC on 27 Jul 1973, as RADM Robert G.W. Williams, Jr., MC, USN relieved RADM Felix P. Ballenger, MC, USN as CO, NNMC, Bethesda.

RADM Ballenger is now the chairman of the Naval Physical Disability Review Board in Washington, D.C.

The 25th commanding officer of NNMC, RADM Williams had previously served as CO, Naval Regional Medical Center, Narragansett Bay, R.I.



**FRONT AND CENTER.**—At the traditional change-of-command at NNMC Bethesda, 27 Jul 1973, principal participants standing in the front row (from left to right) are: RADM D.P. Osborne, MC, USN, Assistant Chief for Personnel and Professional Operations, BUMED; RADM F.P. Ballenger, MC, USN; RADM R.G.W. Williams, MC, USN, and; CAPT D.E. Brown, Jr., MC, USN, Deputy Commanding Officer, NNMC, Bethesda, Md.



**ASSUMES COMMAND.**—RADM F.P. Ballenger, MC, USN (left) is relieved of command of the NNMC, Bethesda, by RADM R.G.W. Williams, Jr., MC, USN (at podium).



## NAVAL STATION REGIONAL DISPENSARY, SAN DIEGO

CAPT Warren W. Hamilton, MC, USN took charge as the Senior Medical Officer at the Naval Station Regional Dispensary in San Diego, Calif., during the summer of 1973.

Formerly Deputy CO of the Regional Medical Center in Long Beach, CAPT Hamilton is a highly respected neurosurgeon with 18 years of naval service. He completed his residency in neurological surgery at the Mayo Clinic, and served in USS *Sanctuary* during the Vietnam conflict.

CAPT Hamilton plans to stress the efficient use of paramedical personnel, the importance of good communication between patients/personnel/commands, and rotation of physicians for additional training and experience in acute/emergency medical care at the Naval Hospital San Diego.



SENIOR MO AT NAV STATION REGIONAL DISPENSARY, SAN DIEGO.—CAPT Warren W. Hamilton, MC, USN.

## U.S. NAVAL HOSPITAL YOKOSUKA, JAPAN

On 22 Aug 1973, CAPT Robert C. Laning was promoted to RADM, with assistance from RADM W. Haley Rogers, Commander U.S. Naval Forces Japan, who pinned on the two-star shoulder insignia. RADM Laning was then relieved of command of U.S. NAV HOSP Yokosuka, by CAPT Dermot A. Murray, MC, USN.

RADM Laning praised the hospital staff for their cooperative and unselfish spirit in maintaining the highest standards of patient care. The Admiral then departed to occupy his present position as Fleet Surgeon on the staff of the Commander-in-Chief, U.S. Pacific Fleet, Pearl Harbor, Hawaii, with additional duties on the Joint Staff as Commander-in-Chief Pacific Medical Officer.

In assuming command of the Naval Hospital Yokosuka, CAPT Murray expressed his intent to do everything possible to maintain the fine tradition of the hospital in supporting the fleet, the Marine Corps and dependents, and to continue the satisfying, close association with Japanese colleagues that has been established.



BUSINESS BEFORE CEREMONY.—Before taking command of the U.S. Naval Hospital at Fleet Activities Yokosuka, Japan, CAPT D.A. Murray, MC, USN (right) was briefed on the hospital's Japanese intern program by: the out-going Commanding Officer, CAPT R.C. Laning (now RADM), MC, USN; and Dr. Michiko Suwa (center), a Japanese intern.

### **ARMED FORCES REGIONAL HEALTH SERVICES SYSTEM**

On 1 Oct 1973, the three Armed Forces Regional Health Services System (AFRHSS) was implemented in 13 CONUS regions. The AFRHSS constitutes a graduated approach to the provisions of peacetime health-care services to the Armed Forces and other beneficiaries, collectively organizing and managing health-care delivery in specified geographic areas, and increasing productivity economically without needless duplication of resources.

In each of the 13 regions there will be a Regional Review Committee, composed of a medical representative from each of the three Services — the Navy to have representatives in ten regions. Committees will continuously assess health services capabilities and operations, and needs for modifying the services, facilities, or other resources within their regions . . . Will also identify management improvements and procedures.

### **FIREROOM HIGH TEMP/HEAT-STRESS CORRECTION PROGRAM**

CNO has approved plan of action to correct shipboard heat-stress problems . . . incorporating heat stress into Performance Evaluation Branch (PEB, BUPERS) visits . . . budget for recurring repairs during regular overhaul (ROH) . . . Self-Help Maintenance Program. Big problems involve funding of several correction programs, and sanitation aboard ships.

### **ACQUISITION OF IBM 1401 COMPUTERS**

The Navy Medical Information Systems Program for regionalization of medical facilities increased requirements for data-processing services at select Naval Regional Medical Centers (NRMCS).

Acquisition of IBM 1401 computer-hardware systems through the Navy Reutilization Program (Navy-owned computer systems) should increase hardware throughput capability to support increased workload, standardize field automatic data-processing (ADP) applications for common functions, permit maximum use of ADP funding resources in the clinical area, enhance ADP personnel orientation and education in computer technology, and provide 3-4 year interim period for integration and traditional health care business ADP applications.

NRMC Camp Pendleton is the programming activity chosen for development and implementation of standard computer programs for common functions at the medical regions. Eleven more IBM 1401 computer systems will be installed in other NRMCS in the near future.

### **PSRO FOR MILITARY SERVICES**

With a view toward implementing Professional Standards Review Organization (PSRO) in the military medical services, in response to the enacted law (PL 92-603), an ad hoc Tri-Service Comparability Study Group is at work. With utilization review and medical-care audit, look for two separate but mutually supporting activities to monitor inpatient care.

## ANTI-SMOKING EDUCATION CAMPAIGN

The Director, Preventive Medicine Division, BUMED is acting consultant to BUPERS-6C24 in waging an anti-smoking campaign through awareness and education, self-help kits, and clinical support.

## SHIPBOARD DENTAL-FACILITY DESIGN

Design criteria for dental spaces have been submitted for a new Destroyer Tender, Submarine Tender, and Sea-Control Ship. Many of the features have been incorporated in the two, new, nuclear-powered aircraft carriers.

To assist the Naval Ship Systems Command in new-ship construction, design criteria have been developed for dental spaces. Some interesting features include: accommodation for right- and left-handed operators, specific spaces for preventive dentistry, central-oral evacuation, dedicated dental air compression and filtration, chrome-cobalt casting, automatic X-ray film processing, Panoramic X-ray exposure, and limited, dental-prosthetic laboratory.

## RECRUITING COMMAND PROJECT/AOCs

In cooperation with recruiting activities, a 90-day trial is in progress, sending selected aviation officer candidates (AOCs) to NAMRI Pensacola for aviation physical examinations.

Results are favorable to date, and at the end of the trial period, look for all AOCs to travel for their initial physical examination at NAMRI PNCLA.

## NAVAL RESERVE PHYSICIANS INCREASE SUPPORT

Reservists are filling in for their active-duty contemporaries, for 14-day periods of active duty . . . . Seven Naval Reserve Medical Companies now augment naval hospital staffs in lieu of performing regular reserve "drills" . . . . Medical-student interest in scholarship program is encouraging, and offers relief as traditional sources of student financial aid diminish . . . . School administrations and students are definitely listening to our recruiting presentations. Student interest in two years' military service as GMOs, a recent trend . . . attributed to lack of immediate draft pressure, and desire to consider options for specialty training more carefully.

Present move is toward a thoroughly integrated Regular Navy/Naval Reserve force, especially in those areas where there is a mutual desire to implement such policy.

## HOSPITAL FUNDING

Action by Congress on the FY-74 appropriation is awaited.

## PROFESSIONAL ADVISORY BOARD SELECTIONS

Statistical review of the Specialty Advisory Committees' (SAC) Graduate Medical Education (GME) recommendations and Professional Advisory Board selections from residency applicants reveals no really significant difference from 1972 percentages and numbers of selection.

Next year's SAC Meeting is being planned for an earlier date . . . will recommend selection from both physicians and medical students that apply for GME.

## MERRY CHRISTMAS . . . AND HAPPY NEW YEAR . . . . ☸





1973 SAC MEETING.—Checking in.



WELCOME ABOARD.—RADM David P. Osborne, MC, USN, Assistant Chief for Personnel and Professional Operations, BUMED Code 3.

## 1973 SAC MEETING

### (Specialty Advisory Committees)

The Fifth Annual Specialty Advisory Committees' Meeting was conducted 1-5 Oct 1973 at the Crystal City Marriott Hotel in Arlington, Va. Converging on the convenient site were more than 150 attendees, comprised of the chiefs of service of graduate education programs in the Navy, selected chiefs of service from non-graduate training hospitals, directors of medical education (deputy commanding officers) from graduate medical-training hospitals, commanding officers of the tenant commands of the National Naval Medical Center, and members of the BUMED staff who are involved with education and training.

Each afternoon, the individual specialists formed working groups which met in separate conference rooms to review in detail the qualifications of each

residency/fellowship applicant. These specialty-working groups formulated selection recommendations for the BUMED Professional Advisory Board, and selected 224 out of 428 applicants requesting inservice training. Of the 428 applicants, 75% were Naval officers; there were one Army, one Air Force, and three Public Health members. After completing their recommended selection of residents and fellows for training during Fiscal Year 1975, the committees addressed broader issues affecting graduate-medical education, and specific aspects of training which impact upon the respective specialties.

Three profitable plenary sessions were conducted on Tues., Wed., and Thurs. mornings. Following the welcoming and introductory remarks ably delivered by



RADM David P. Osborne, MC, USN, Assistant Chief for Personnel and Professional Operations, BUMED; CAPT M. Museles, MC, USN, Assistant to RADM Osborne for Education and Training; and CAPT E.B. McMahon, MC, USN, Director Professional Division, BUMED; an expectant aura of pronouncement permeated the theater, and the Surgeon General mounted the podium.

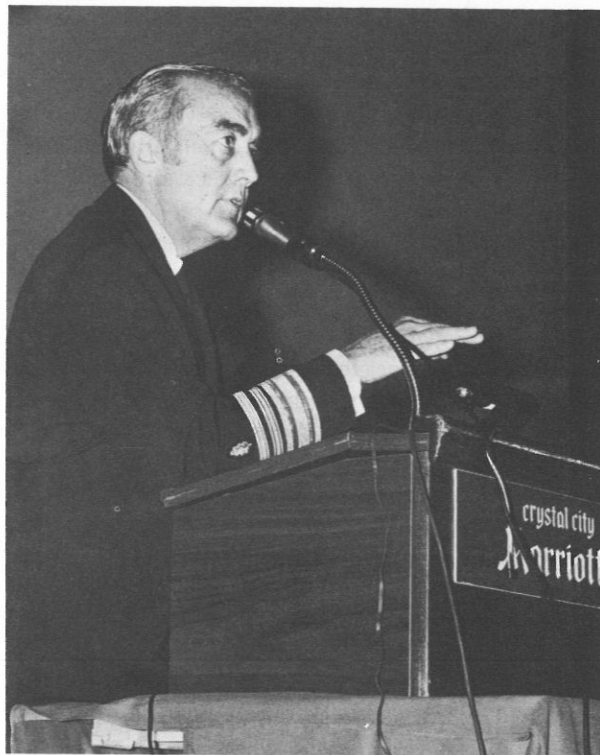
As VADM D.L. Custis, MC, USN quietly but deliberately proceeded with the Surgeon General's opening remarks to the 5th Annual SAC Meeting, it rapidly became evident that the air of anticipation had been accurately prophetic. It was a straight, no-nonsense address which cut swiftly to the present crisis, logically developed a review of the growing assets, conveyed to the attendees a sense of strong determination, and inspired renewed commitment. Pointing out that it is at the local level where "... the most people participate in any meaningful way," VADM Custis called upon the leaders assembled before him to "... symbolize ... voice and confirm the deeply rooted values of" their Corps, striving to create a better environment for their people whose needs "... cannot be adequately ... met by ... rhetoric from Washington."



SETTING THE CLIMATE FOR SAC.—CAPT E.B. McMahon, MC, USN, Director of the Professional Division, BUMED Code 31.



INTRODUCING.—CAPT M. Museles, MC, USN, Assistant to RADM Osborne for Education and Training, and recently appointed the first Executive Secretary of the Board of Regents of The Uniformed Services University of Health Sciences.



THE SURGEON GENERAL, VADM D.L. CUSTIS, MC, USN.—"We can be brought down, *right now*, by the volatility of our aspirations or by our incapacity to aspire."



E. PELLEGRINO, M.D.—“Primary care must become a major effort for a medical school . . . . Without adrenalin nothing is accomplished.”

E. Pellegrino, M.D., Vice President and Director of the Health Center, SUNY, Stony Brook, L.I., N.Y. Medical School offered an engaging review of “Current Trends in Medical Education.” Dr. Pellegrino viewed current forces from outside the medical profession — the public consumers of health-care services — as an exciting challenge vice “noisome disturbance of our equilibrium.” In response to these forces, 50%, perhaps more of our medical-school graduates must be persuaded to practice general medicine. Academicians must begin to channel their students toward intended goals, he noted, making it imperative to conduct a sweeping reexamination of the basic sciences, and to formulate a multitrack curriculum. There is an urgent requirement to define and equate competence, accountability, continuing education, temporal licensure, and reexamination. In extending educational opportunity for those who wish to enter the medical profession, the center of gravity has moved away from Washington, D.C., Dr. Pellegrino observed, to the states.

Complimenting the Navy as a recognized leader in redefining all of the roles in the health-care system, the dynamic speaker pointed out that there are presently 256 so-called health professions, an absurdity which must be altered. Dr. Pellegrino outlined a functional

concept of deciding upon the basic roles required to deliver health care, and then moving back to formulate the educational preparation necessary to these functions.

J. Nunemaker, M.D., Executive Director of the American Board of Medical Specialties, Evanston, Ill., addressed “The American Board of Medical Specialties (ABMS): Meeting the Challenge of Changing Undergraduate and Graduate Medical-Education Patterns.” Dr. Nunemaker identified the concerns of ABMS, emphasizing the necessity for evaluation of initial and continuing competence of physicians. A tracking study conducted by the National Board of Medical Examiners, he observed, revealed that only 50% of all specialists are certified by a specialty board. ABMS is deeply concerned with manpower quality (and not quantity). Recertification and relicensure are favored by all the specialty boards, he noted, except for the Board of Neurosurgery. Dr. Nunemaker also reported that ABMS has reorganized its central office, with a Division of Special Studies and a Division of Special Services.

The second plenary session began with a “Status Report on Navy Graduate Medical Education,” by CAPT M. Museles, MC, USN and CAPT S. Barchet, MC, USN,



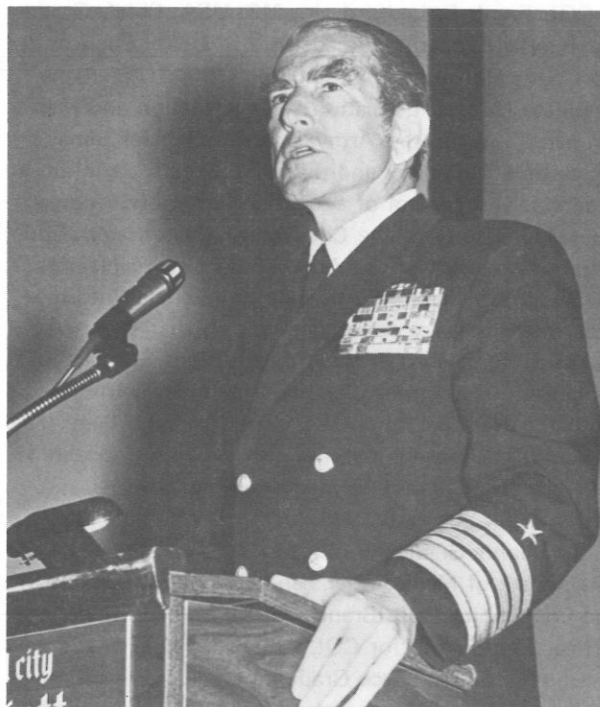
J. NUNEMAKER, M.D.—“The matching program will no longer be a cookbook guidance for running postgraduate programs.”



THE FUTURE OF MEDICAL EDUCATION.—Participating in panel discussion are (from left to right): CAPT S. Barchet, MC, USN, Moderator; CAPT M. Museles, MC, USN; E. Pellegrino, M.D.; CAPT J.W. Cox, MC, USN; and J. Nunemaker, M.D.

Head, Training Branch of the Professional Division, BUMED. Attendees appreciated the frank input which these officers made available.

Admiral E.R. Zumwalt, Jr., USN, Chief of Naval Operations was warmly received, and demonstrated, during his talk a perceptive understanding of present medical problems. The Admiral enumerated significant aspects of the impact exerted by an all-volunteer Navy, including: the emphasis on education at all levels; the need to "... eliminate barnacles from the past ... to enhance job satisfaction"; elimination of institutional racism, and implementation of Women's Lib amendment (eight women now in flight training; women in USS *Sanctuary* ship's company); and family togetherness (3 years sea duty/3 years ashore). The current recruiting and reenlistment figures appear highly favorable, the CNO reported. Confronted with the need for modernization of the Navy in the face of diminished funds and personnel (400 obsolete ships eliminated over the past five years), Admiral Zumwalt nevertheless reiterated his strong support, and his desire to do everything possible to fund medical requirements. The importance of medical benefits in recruiting and retention of Naval personnel, the Admiral commented, cannot and will not be overlooked.



CNO — ADM E.R. ZUMWALT, JR., USN.—Modernization in the face of diminished funds and personnel is an awesome task.





COL F. LEDFORD, MC, USA.—“What does the AMA really mean when they say that the free-standing internship year is going to disappear?”

COL Frank F. Ledford, Jr., MC, USA, Chief, Graduate Health Education, Academy of Health Sciences, Fort Sam Houston, Tex., spoke on the “U.S. Army Graduate Medical Education — Organization and Management.” While the Army Surgeon General remains responsible for policy and planning aspects, all inhouse programs and control of education have now become the responsibility of the Chief of Graduate Health Education, as a result of the Army’s major reorganization. COL Ledford shared worthwhile professional information with his Navy colleagues, noting that the Army claims 1059 persons in Health Professions Scholarship Programs. He commented that the Army withdrew from the National Intern/Resident Matching Plan (NIRMP) because the procurement programs appeared very promising, and it seemed desirable to select and notify applicants early, without further complications.

MAJ John G. Brady, MSC, USAF represented the Directorate of Medical Plans and Resources, Personnel and Educational Plans Branch, USAF Surgeon General’s Office. Standing in for COL Anderson, MAJ Brady addressed “U.S. Air Force Graduate Medical Education — Organization and Management.” A particularly appropriate and welcome substitute, one Ph.D. degree and one uniform later, MAJ Brady is an ex-Navy corpsman.

As the Major explained, the Air Force medical-education system is organized much like that of the Army, with the Surgeon General engaged in policy and planning, and the operational and functional responsibility removed to Randolph AFB. He likened the Air Force Institute of Technology (AFIT) function to that of registrar, and noted new indications for a healthy return to the campus with ROTC units.

The third plenary session was devoted, in part to an informal discussion of current issues relating to professional personnel, and was efficiently guided by CAPT E.B. McMahon, MC, USN. CAPT McMahon announced that a two-week course in Executive Medicine Management Education will replace the Captain-Selectee Indoctrination Course, and urged the participants to identify early those in their charge who manifest the academic bent.

RADM G.H. Reifenshtein, MC, USNR, Director, Clinical Investigation Control Center, NNMC, Bethesda, provided a timely presentation of “The Navy’s Clinical Investigation Program: A Status Report.”

RADM Emmett H. Tidd, USN, Commander, Navy Recruiting Command, Arlington, Va., addressed “Medical Recruiting.” Having assumed full responsibility to supplant the Draft for all of the Navy, RADM Tidd



MAJ JOHN G. BRADY, MSC, USAF.—“The AFIT functions as a kind of registrar.”





RADM E.H. TIDD, USN.—"I'm still looking for the 'GO — NO GO' gauge as an indicator of potential career orientation. If we could identify this we could save a tremendous amount of money."

described the coordinated effort of the Recruiting Command; BUMED; Recruiting Program Coordinator, CAPT Wendell A. Johnson, MC, USN; eight regional medical program officers; and 42 district commanders. The Admiral emphasized the importance of naval hospital COs as contact and selling agents. In view of the tremendous competition imposed by other markets and escalating salaries, RADM Tidd urged all those present to actively seek opportunities for selling NAVY to medical students. Direct mail, he commented, may not provide our best means of contact.

As the first Executive Secretary of the Board of Regents of the new University, CAPT Melvin Museles, MC, USN addressed "The Uniformed Services University of Health Sciences: Current Status." CAPT Museles listed the distinguished members of the Board of Regents, which is expected to select key faculty members (civilian and military) to assist in planning the curriculum by the early summer of 1974.

A highlight of the week was astronaut CAPT Joseph P. Kerwin, MC, USN, whose report on "The Skylab Project" was enthusiastically received. Dr. Kerwin indicated that adaptation to weightlessness is unpredictable and varies among individuals; there is no apparent correlation with motion sickness, and no effective

means of preventing it, at present. He observed no significant difference in oxygen consumption and CO<sub>2</sub> production as compared with preflight data. Rapid weight (water) loss, amounting to 5% of the body weight occurred in flight, especially in the lower half of the body. Blood volume and red blood cell (RBC) mass decrease in flight, with deterioration greatest in the first several days, he commented. Appetite remains good, routines of housekeeping pose no problem, and body exercise is highly desirable. (The bicycle ergometer has been especially popular.) Familiar complaints are: head fullness, muscle flaccidity, insomnia, and difficulty in finding a comfortable position. Astronauts seem all right after splashdown so long as they remain in the horizontal position. Upon assuming a position perpendicular to the earth's surface, however, deficient blood volume, postural hypotension, vertigo, and broad-based gait appear. Early readaptation may in fact rob the astronaut of a little additional blood volume. Symptoms generally abate after three days and exercise is resumed in two or three weeks, but six to seven weeks are required for RBC mass to return to normal.

CAPT Kerwin remarked that the data obtained would be analyzed for the next two or three years, but he would venture to say that there is no substantial



ASTRONAUT CAPT J.P. KERWIN, MC, USN.—"Permanent human presence in space will undoubtedly be possible in the 1980s and 1990s."



COFFEE BREAK.—Deep in conversation, from left to right, are: CAPT R.K. Barton, MC, USN; CAPT D.Q. Wilson, MC, USN; and RADM R.L. Baker, MC, USN.



THE RADIOLOGY SPECIALTY GROUP



THE OTOLARYNGOLOGY SPECIALTY GROUP



THE OPHTHALMOLOGY SPECIALTY GROUP

opposition to living in space for a period of at least two to four months. The problems which will arise in space will be clinical-medical problems.

At the banquet dinner held in the Crystal City Suite on the evening of 3 Oct., the Honorable Abraham A. Ribicoff, Senator (D) from Connecticut, was guest speaker. As co-author of the recently introduced "Catastrophic Health Insurance Plan and Medical Assistance Health Act of 1973," the Senator outlined impressive provisions therein for providing: medical assistance to the poor, certified health insurance for most families, and catastrophic health insurance. Hearings on the bill are anticipated in early 1974. Through small increments in Social Security payments, a ceiling would be placed on medical costs for every family — \$2000/year, Senator Ribicoff explained. Present health benefits



THE INTERNAL MEDICINE SPECIALTY GROUP



THE FAMILY PRACTICE SPECIALTY GROUP

under Medicaid would be broadened, and fiscal relief for state and local governments would result. The plan would make available adequate private health insurance, at group rates, to many persons who are not now covered. The Senator's medical objectives were most interesting to an audience composed of physicians who have devoted some years to providing group-health care. Following this presentation, Senator Ribicoff engaged in informal discussion with the SAC members. Admired for his candor, interest, and sound advice, the Senator received a standing ovation at the conclusion of his talk.

By popular acclaim, for duty above and beyond the Hospitality Suite, CAPTs W. Cox and M. Museles were nominated for awards as "hosts with the most." Unfortunately there are no such awards. Such dedication must surely be its own reward.

We hope that those responsible for planning, organizing, and carrying the SAC meeting sensed the high degree of positive response which their efforts evoked. Aside from the fruitful deliberations of SAC, there was a healthy resurgent interest and encouragement in Navy Medicine, which was never more opportune.



GUEST SPEAKER APPLAUDED.—The Honorable A.A. Ribicoff (center) was welcomed by the Surgeon General, VADM D.L. Custis, MC, USN (right); and the Deputy Surgeon General, RADM H.S. Etter, MC, USN (left); during the informal banquet dinner conducted on the evening of 3 Oct.



DR. SPEAR (left) and Dr. (center) are seated at a table with Dr. (right) during the evening of the event. The men are all wearing dark suits and ties. The table is set with glasses, plates, and a decorative lamp.



## I N F O R M A L S



### Acknowledgment:

We wish to express appreciation for efficient coverage to photographers HM2 Lawton and HM2 Doonan, USN, Photography Division of the Media Dept., Naval Medical Training Institute, NNMC, Bethesda, Md. 🇺🇸

# PHYSICIAN'S ASSISTANTS:

## An Extension of the Physician\*

By Henry J. Amann, Jr., Managing Editor,  
National Naval Medical Center News,  
NNMC, Bethesda, Maryland 20014.

Physician's Assistants, the newest members of the health-care team, are trained to function as extensions of the primary-care physician. Under the supervision and responsibility of the medical officer, Physician's Assistants will handle outpatient problems of a routine nature, selected trauma cases, and medical emergencies.

The Navy currently has two ongoing Physician's Assistant programs: one at the George Washington University in Washington, D.C., and another at the U.S. Air Force School of Health Care Sciences at Sheppard Air Force Base, Tex. The Sheppard program is affiliated with the University of Nebraska. Graduates of both programs earn 90 semester-hours credit from the affiliated university.

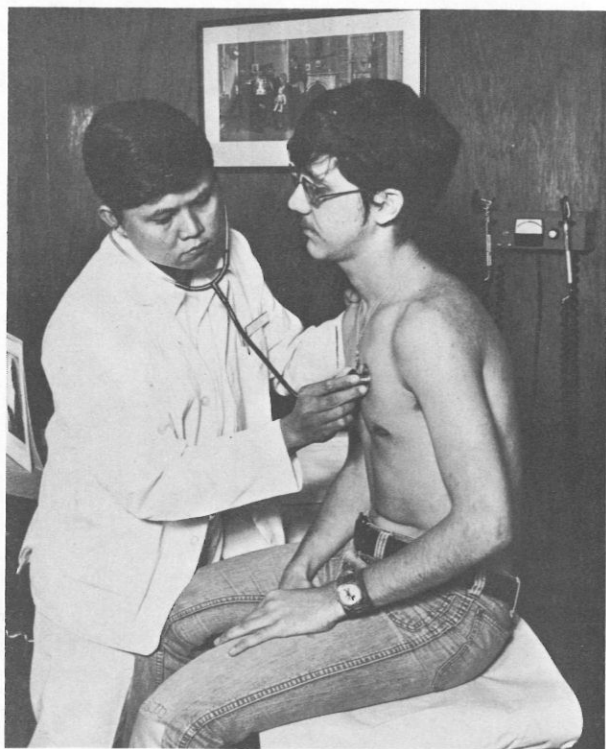
During their first year of unique education, the five Physician's Assistants pictured here received instruction in various subjects, including anatomy, physiology, chemistry, pharmacology, history-taking, and physical examination. They also served in clinical clerkships at

the George Washington and District of Columbia General Hospitals, under the watchful supervision of physicians from George Washington.



THE GENERALIST CONTACTS THE PATIENT.—HMC Dan Hutchinson (right) interviews a patient and reviews her medical history.

\*The photographs accompanying the above article were taken by HM2 Mick Lawton, USN; Photography Division of the Media Department, Naval Medical Training Institute, NNMC, Bethesda, Md.



CONDUCTING THE PHYSICAL EXAM.—HM2 Jose Rodriguez, USN (left) performs auscultatory portion of the chest examination.



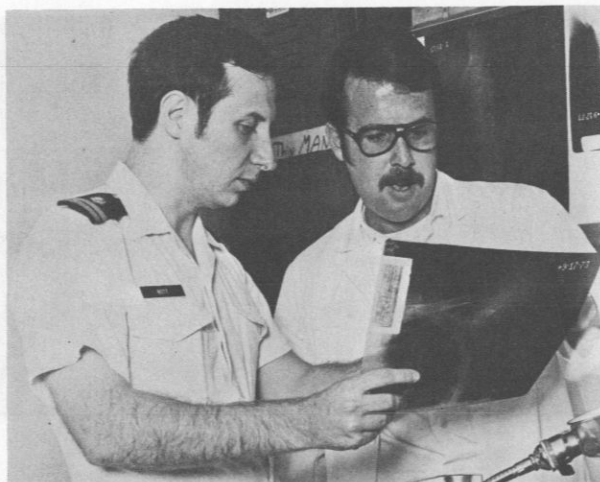
REVIEWING HOSPITAL CHART.—HM1 Guy Eastman (left) reviews a patient's record with LCDR Doris Fitzgerald, NC, USN.



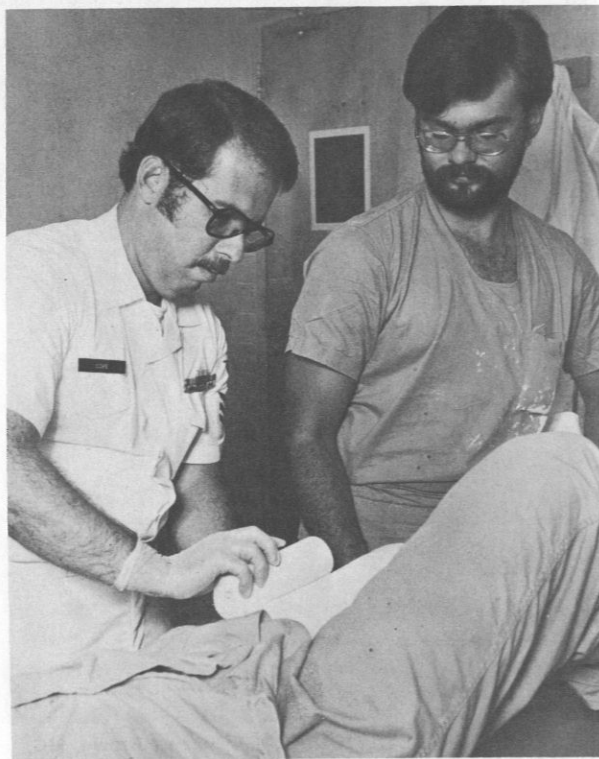
EKG INTERPRETATION.—CAPT Herbert Brown, MC, USN (right), Chief of Medicine and Outpatient Service at Naval Hospital Annapolis, Md., points out the interesting features of an electrocardiogram to HMC Robert Dunlap, USN.

These five Physician's Assistants who have recently commenced the second phase of their training at NNMC, Bethesda are: HMC Daniel Hutchinson, HMC Robert Dunlap, HM1 Ronald Cope, HM1 Guy Eastman, and HM2 Jose Rodriguez. As members of the class at George Washington University, the five Physician's Assistants-in-training are working both at NNMC Bethesda, and at the Naval Hospital Annapolis, Md. Other classmates have been assigned for training at the Naval Hospitals Philadelphia, and Portsmouth, Va. The second phase of training involves working for a year under the continuous, direct supervision of a physician, and rotating through various hospital services such as OB-GYN, Orthopedics, Surgery, and the Emergency Room. Upon the successful completion of this second year, the trainees will be promoted to the grade of Warrant Officer; E-7s and above will be commissioned WO2, while E-6s and below will be promoted to WO1.

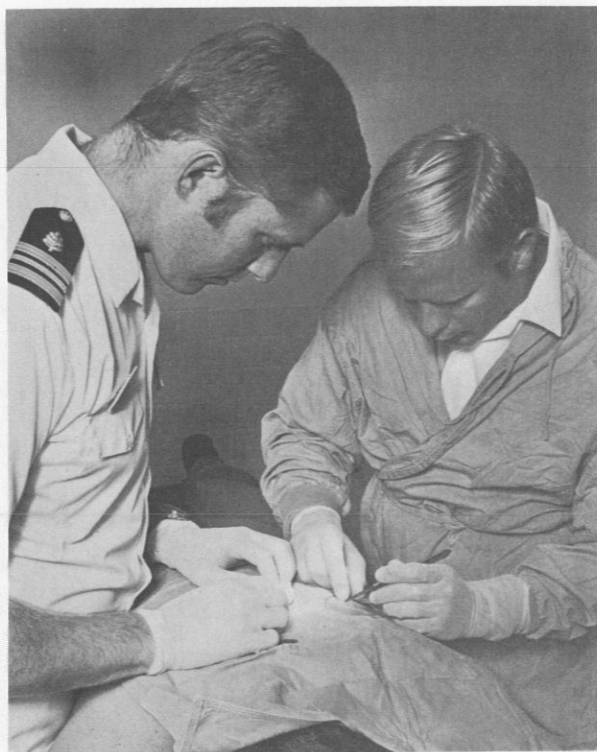
According to CAPT Carl M. Voyles, MC, USNR, Chief of the Outpatient Service and Medical Director for the Physician's Assistant (PA) program, the PA will be "the generalist who sees the patient before the specialist does." CAPT Voyles cited the historic preceptor concept in medical training, recalling the venerable customary preceptorship whereby medical-school graduates



**VIEWING THE X-RAY FILM.**—LT William K. Bott, MC, USN (left) discusses the significance of an X-ray examination with HM1 Ronald Cope (right).



**IMMOBILIZING A FRACTURE.**—HM1 Ronald Cope (left) and HA Robert Bieschke (right) apply a plaster cast.



**UNDER THE SURGEON'S WATCHFUL EYE.**—HM1 Guy Eastman (right) excises a cyst from patient's back, as LCDR Donald S. Prough, MC, USNR (left) assists.

worked directly under an established surgeon, until sufficient competence was demonstrated to establish the young doctor as an independent practicing physician, in the judgment of his preceptor. In similar fashion, each PA is assigned to work with a physician preceptor.

CAPT Voyles also emphasized that PAs are not doctor replacements, but serve literally as an extension of the physician who provides constant supervision.

The Project Director, CDR Joseph S. Cassells, MC, USN, reports that the Navy has set a goal to create 720 PAs by 1980. The PAs will be trained and utilized as generalists, and no plans are projected for PAs to specialize. Nurse Practitioners will be specialists.

CDR Cassells commented that there are no present procedures for recruiting PAs from civilian life. The Navy is exploring other institutions of training, however, where Physician's Assistant programs might be established for Navy personnel.

To qualify for the PA program, aspiring personnel must hold the rate of HM2, or above, with at least four years of service. It is hoped that many who can qualify will investigate this possibility, for a challenging career of great potential value to the individual, and to whatever community he may choose to serve. ☸





## ORAL HISTOPATHOLOGY SERVICE

*To the Editor:* I noted with pleasure the excellent article describing "Oral Pathology and the Histopathology Service" of the Naval Graduate Dental School in *U.S. Nav Med* 62(2):8-11, Aug 1973. Especially attractive were the many photographs of the technicians in the laboratory in which this important work is performed. It would seem appropriate to add that the pictures represented the renovated Anatomic Pathology Laboratories at the National Naval Medical Center, Bethesda, Md. As a matter of record, the Oral Histopathology Service is a welcome tenant in the Hospital Laboratory spaces, and during their training course, oral pathologists spend one year in the Hospital Residency Training program in anatomic pathology. A happy marriage of technical and professional talent results, and speaks well for the concept of integrated geography within medical centers.

CAPT M.J. Valaske, MC, USN,  
Chairman, Dept. of Laboratory Medicine,  
NNMC, Bethesda, Md.

## NEISSERIA PHARYNGITIS

*To the Editor:* In response to the letter by LT S.W. Bondurant, MC, USNR, in the Sep 1973 issue of *U.S. Nav Med*, we would make the following comment. Due to the lack of specific morphologic distinctions among bacteria, a specific etiologic diagnosis can not be obtained by examining Gram's stain smears of exudate or pus. Specifically, because the meningococcus, saprophytic *Neisseria* (normal-mouth flora), and *Mima-Herellea* species can present the same morphologic

appearance on Gram's stain as *Neisseria gonorrhoeae*, and because of the epidemiologic significance of *N. gonorrhoeae* infection, an etiologic diagnosis should be made only after cultural confirmation has been obtained.

Regardless, since *N. gonorrhoeae* is a well recognized cause of pharyngitis, we would agree that a presumptive diagnosis can be made, and therapy instituted on the basis of clinical information with smear exam.

- . LCDR Glenn R. Hodges, MC, USNR,  
Head, Infectious Disease Section;
- . LCDR Thomas E. Root, MC, USNR,  
Assistant Head, Infectious Disease Section;
- . LCDR Robert W. Hilberg, MC, USNR,  
Head, Hematology Section;  
Nav Hosp Great Lakes, Ill.

## PORT HUENEME ARTIST

*To the Editor:* Thank you for the kind mention of my paintings in "Little Folk Intrigued at Nav Hosp Port Hueneme," *U.S. Nav Med* 62(3):47, Sep 1973.

It was for me a pleasure to donate my time and talents to this fine hospital (with an equally fine staff). I should also like to express appreciation to CDR Edith Prencipe, NC, USN, Chief of Nursing Service; and to LCDR Mark Freedenberg, MC, USNR (released from active duty in June 1973); they paid for the paints and supplies.

Nancy Bartalamay (DEPT-USNR)  
1845-A Terrier  
Pt. Mugu, Calif.


## UNIFORM AT MEETINGS

*To the Editor:* I recently attended the Clinical Congress of the American College of Surgeons in Chicago. I was somewhat amazed by the lack of the Navy-blue uniform at these meetings. What has happened to the tradition that Naval medical officers who have been excused by their commands, and particularly those who have been financed by the Government to attend a national meeting, are to wear their uniform on the first day of the general sessions of the meeting?

I, for one, am not ashamed that I am a member of the Medical Corps of the Navy, and I want my civilian

colleagues to know that the Navy is participating in national meetings. It seems to me, at this time when the military is not very popular in the Nation, that it is particularly important that every effort should be made to advertise our interests and participation in national medical matters.

Here is one affirmative vote for rejuvenating this tradition, and urging commanding officers to emphasize its practice.

CAPT C.H. Lowery, MC, USN,  
Chief of Surgery,  
Nav Hosp Camp Pendleton, Calif. 

## WEIGHT REDUCTION IN EARNEST

ENS Robert P. Heisler, MSC, USN is actively helping people along the road to better health through his knowledge of food, as Assistant Chief of the Food Service for Dietetics at Naval Hospital Pensacola, Fla. Responsible for the local implementation of the Navy-wide weight-reduction program, ENS Heisler remarked: "I am urging interested personnel on the hospital staff to contact me for information on a special calorie-controlled menu, and am pleased to be doing this. Actually, I need to lose weight myself."

CAPT Charlotte Stone, Chief of the Nursing Service at the hospital, promptly requested that staff nurses be allowed to join the first who sign up for the program.

LT Neil R. Petersen, MSC, USN, Chief of the Food Service, explained that the special menu cannot be personalized, and therefore the program is strictly intended only "for Naval Aerospace and Regional Medical Center staff members on active duty in the Navy."


ENS Heisler completed formal studies at Ohio State University in 1972, and is a member of the American Society of Hospital Food Service Administrators, the American Dietetic Association, and the Florida Dietetic Association.

In addition to the newly instituted weight-reduction program for staff members, ENS Heisler is also involved in planning hospital therapeutic and special diets. On a weekly basis, he meets with patients referred to him by physicians, for guidance and direction in following diabetic and weight-reduction diets.

—PAO, Nav Aerospace and Reg Med Center, Pensacola, Fla.

*(That's a realistic attack on a gut problem. You're not alone, Pensacola. For whatever it's worth, BUMED found it necessary to do away with the cafeteria altogether.—Ed.)*



CUTS CALORIES.—ENS Robert P. Heisler, MSC, USN, Assistant Chief of Food Service for Dietetics at Nav Hosp Pensacola, Fla. 



### RESIDENCY TRAINING POSITIONS AVAILABLE

The following residency-training positions are available in naval hospitals at the location indicated, for training to begin in the summer of 1974:

Anesthesiology - Philadelphia, Pa.; Portsmouth, Va.; and San Diego, Calif.

Pathology - Bethesda, Md.; Oakland, Calif.; Portsmouth, Va.; and San Diego, Calif.

Interested Medical Corps officers are invited to apply for the above programs without delay. Procedures for preparing and submitting requests are contained in BUMED INSTRUCTION 1520.10F of June 1972. For further information, write or call Bureau of Medicine and Surgery, Training and Clinical Services Branch (Code 316), Navy Department, Washington, D.C. 20372. Phone: (202) 254-4280/4281 — Code 31, BUMED.☞

### PERIODIC PHYSICAL EXAMINATION OF MEMBERS ON TDRL

By law a member of the Naval Service may be placed on the Temporary Disability Retired List (TDRL) for a maximum of five years. During that period the member is required to undergo periodic physical examinations which are conducted at least every 18 months, and final disposition in each case must be effected prior to the expiration of the five-year period. The law further stipulates that the pay of a person on the Temporary Disability Retired List be stopped after that person has been on the list for the maximum period of time, if final disposition is not made.

Current administrative practices have, in some instances, particularly in those cases where the member

exercises his right to a formal hearing of the proposed disability findings, resulted in delays that impose an unwarranted hardship upon members affected by the prescribed time limitations. Accordingly, effective immediately, orders will be issued for a final examination well in advance of the member's five-year deadline. This procedure will provide for an examination to be conducted nine months prior to the cutoff date.

A pink "urgent" slip, affixed to the orders in the case of Navy members, and bold-type annotation on the orders in the case of Marine Corps members, indicate that a member's pay-cutoff point is approaching. All examination-paperwork processing must be completed, no later than two months after the month indicated in the orders. Such procedure is designed to allow all records of the final examination to reach the Office of Naval Disability Evaluation (ONDE) six months prior to the five-year cutoff date. — Code 33, BUMED.☞

### NAVAL RESERVE MEDICAL SPECIALIST REGISTRY

In an attempt to provide a more clearly defined organizational structure for the Naval Reserve Medical Corps component, CAPT Joseph H. Miller, MC, USNR-R, of Memphis, Tenn. has developed a Registry of Naval Reserve Physicians.

The Registry will identify physicians by rank, specialty, geographic location, and availability. It will provide a mechanism for better utilization of medical manpower in both long-range and short-term situations. Significant concurrent benefits will be: the establishment of dialogue between geographically separated medical personnel within the reserve component; introduction of a more meaningful reserve participation based on need;

better exposure of the regular Navy to the reserve establishment, and vice versa.

If you have not already been approached regarding participation, and wish to become part of this effort, you may contact the appropriate Specialty Director listed below, or CAPT Miller, who heads the Neurosurgery Registry.

#### **ANESTHESIOLOGY**

CDR John Tolmie, MC, USNR-R  
1543 Abbey Court  
Winston-Salem, NC 27103

#### **GENERAL PRACTICE**

CAPT Albert L. Solgaard, MC, USNR-R  
645 Pacheco Blvd.  
Los Banos, CA 93635

#### **GENERAL SURGERY**

CAPT H. Turner Edmondson, MC, USNR-R  
Department of Surgery  
V.A. Hospital  
Augusta, GA 30904

#### **INTERNAL MEDICINE**

CAPT Charles Brink, MC, USNR-R  
473 Main Street  
Shrewsbury, MA 01545

#### **NEUROSURGERY**

CAPT Joseph H. Miller, MC, USNR  
220 S. Claybrook Street  
Memphis, TN 38104

#### **OBSTETRIC-GYNECOLOGY**

CAPT James A. Austin, MC, USNR-R  
926 E. McDowell, Suite 33  
Phoenix, AZ 85006

#### **OPHTHALMOLOGY**

CDR Norman Sawyer, MC, USNR-R  
2024 Randolph Road  
Charlotte, NC 28207

#### **ORTHOPAEDIC SURGERY**

CAPT Daniel Scott, MC, USNR-R  
188 S. Bellevue  
Memphis, TN 38104

#### **OTOLARYNGOLOGY**

LCDR Phillip Mathias, MC, USNR-R  
1428 Dogwood Road  
Morgantown, WV 26505

#### **PATHOLOGY**

CAPT Giles D. Toll, MC, USNR-R  
3846 S. Magnolia Way  
Denver, CO 80237

#### **PEDIATRICS**

CAPT Robert Summitt, MC, USNR-R  
848 Adams Avenue  
Memphis, TN 38103

#### **PREVENTIVE MEDICINE**

CDR Dale Ducommun, MC, USNR-R  
1905 Brookfield Drive  
Midland, Michigan 48640

#### **PSYCHIATRY**

CAPT Paul G. Ecker, MC, USNR-R  
631 Saint Georges Road  
Philadelphia, PA 19119

#### **RADIOLOGY**

CDR John R. Corbett, MC, USNR-R  
4411 Cascade Road  
Wilmington, NC 28401

#### **THORACIC SURGERY**

CDR Frederic Primich, MC, USNR-R  
28 Oak Avenue  
Metuchen, NJ 08840

#### **UROLOGY**

LCDR Jerry McRoberts, MC, USNR-R  
Department of Urology  
University of Kentucky Medical Center  
Lexington, Kentucky 40506

### **SURVIVOR BENEFIT PLAN FOR RETIRED NAVAL RESERVISTS**

The Survivor Benefit Plan was established on 21 Sep 1972, and replaced the Retired Serviceman's Family Protection Plan as a means of providing an annuity for your eligible beneficiaries.

Naval Reservists qualifying for retirement pay at age 60 under the provisions of Title 10, U.S. Code, Section 1331, are automatically covered by the Plan at the maximum level unless, prior to eligibility for retired pay, they make a choice to be covered by a lesser amount or elect no coverage whatsoever.

Information regarding the intricacies of the Survivor Benefit Plan should be available through your parent command, or your Naval District Commandant. All

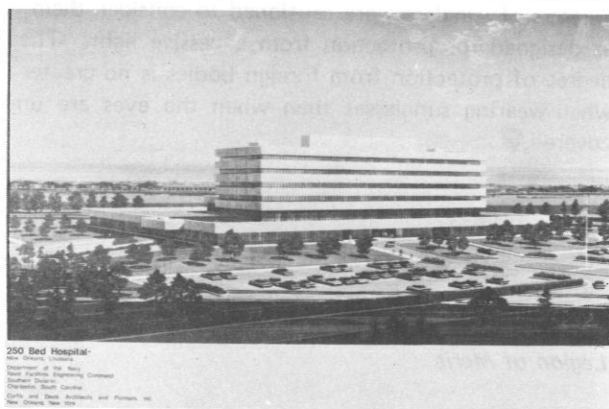


Reservists will be furnished information by BUPERS when they make application for reserve retirement immediately before reaching the age of 60 years. — Code 36, BUMED. 🍀

## GROUNDBREAKING AT NSA NEW ORLEANS

Formal groundbreaking for the proposed \$15 million Naval Hospital in Algiers, La., were conducted on 3 Nov 1973. The six-story, 250-bed hospital will serve more than 20,000 active duty and retired personnel, and their dependents in the area of New Orleans, La.

Expected to be completed in the fall of 1976, the new medical facility will be constructed of fire-resistant



ARTIST'S CONCEPTION. — The six-story, 250-bed hospital is to be constructed at the Naval Support Activity in New Orleans, La. Formal groundbreaking occurred on 3 Nov.



GROUNDBREAKING CEREMONIES FOR NAVAL HOSPITAL IN ALGIERS. — Congresswoman Lindy Boggs assists the Navy Surgeon General, VADM D.L. Custis, MC, USN. Standing to the right (from left to right) are: Congressman F. Edward Hebert, Chairman of the House Armed Services Committee, whose effort and foresight did much to bring about the new construction; RADM R.E. Riera, Commandant of the 8TH Naval District; and New Orleans Councilman-at-Large James Moreau.

materials and equipped with an ultramodern sprinkler system. Emphasis will be placed on hurricane and earthquake protection. The edifice is being built in the center of a 20-acre tract of land bounded by the Naval Support Activity on the east, and the Mississippi River on the north. Twelve old buildings, some dating back to the days of World War I, were razed to make room for the new hospital complex.

Included among the distinguished participants in the groundbreaking ceremony were: VADM D.L. Custis, MC, USN, the Navy Surgeon General; Congressman F. Edward Hebert, Chairman of the House Armed Services Committee; Congresswoman Lindy Boggs; New Orleans Councilman-at-Large, James Moreau; VADM Damon C. Cooper, Chief of Naval Reserve; RADM R.E. Riera, Commandant of the 8TH Naval District; and CAPT G.M. Ricketson, MC, USN, District Medical Officer. 🍀

## UNIFORMED SERVICES RETIREMENT MODERNIZATION ACT

The Department of Defense has announced that action is still pending on the Uniformed Services Retirement Modernization Act proposal, which was sent to the Congress in March 1973.

One reason for the delay is that the legislation is extremely complex, and will require considerable study by the staffs and Members of the Armed Services Committees. To date, neither the House nor Senate committees has had the opportunity to extensively examine it.

One Defense official stated it is difficult to predict, with any degree of certainty, when the Congress will consider the legislation. It is possible that neither the House nor the Senate will hold hearings on the proposal prior to the close of the calendar year. It is more likely that the House will hold hearings shortly after the second session of the 93rd Congress resumes. However, the Senate will probably not hold hearings until next spring or summer.

Meanwhile, there have been no changes made to the original proposal, either by the Department of Defense or by the Congress.

Pentagon officials hope the Retirement Modernization plan will be left intact by the Congress as hearings progress, because of the amount of study that went into the development and design of each of its provisions. The proposed legislation constitutes a complete package necessary to modernize an outdated retirement system, that was designed for a much smaller defense force in a much different economic era. — ASD (M&RA), Armed Forces Information Service News Feature, Washington, D.C. 🍀

## OFFICIAL INSTRUCTIONS AND DIRECTIVES

BUMEDINST 5430.4 of 1 Aug 1973

*Subj: Bureau of Medicine & Surgery Organization Manual*

This instruction has been issued to all one-, two-, and three-digit BUMED codes to bring the Bureau of Medicine and Surgery (BUMED) Organization Manual (formerly NAVMED P-1224) into the Navy Directives Issuance System.

The BUMED Organization Manual contains the official organization charts and functional statements describing the approved organization of the Bureau, and is assigned to BUMED offices as required.

BUMEDNOTE 6550 of 25 Jun 1973

*Subj: Nursing Care Plan*

This notice is directed to all hospitals, activities having dispensaries with authorized operating beds, and ships having medical personnel.

The present Patient Care Plan (NAVMED 6550/1 [4-66]) was found to be inadequate for planning nursing care which includes systematically assessing and identifying patients' problems, setting objectives of patient response, and establishing methods for accomplishing them. The Nursing Care Plan has been designed to implement the forms specified in Nursing Assessment, and the Nursing Care Plan I and II, in order to accomplish the following: help nursing personnel set priorities; plan more systematic communication, and more continuity and coordination of care; assist in the evaluation of nursing care given; and enable nursing personnel to comply with Nursing Service Standard IV in the *Accreditation Manual for Hospitals*, Joint Commission on Accreditation of Hospitals, Chicago, 1970.

BUMEDNOTE 6810 of 20 Aug 1973

*Subj: Sunglasses; nonimpact and impact-resistant*

The purpose of this notice is to alert personnel to the danger inherent in wearing spectacles, and to differentiate between impact-resistant and nonimpact-resistant sunglasses.

The Food and Drug Administration has decreed that all spectacles manufactured after 31 Dec 1972 will be

impact-resistant. Personnel should be made aware of the type sunglasses they have. Heat-treated impact-resistant sunglasses are issued in cases bearing the legend, "Impact-Resistant Treated." All sunglasses in cases which do not bear the marking cited above shall be considered as nonimpact-resistant.

Impact-resistant lenses are not safety lenses and should not be considered as such. Impact-resistant lenses may, but do not necessarily, offer a greater degree of resistance to fractures than do untreated lenses. Lenses cannot be expected to provide protection against other than small, slow-moving objects. Projectiles, such as thrown baseballs, pellets from "BB" guns, or gravel thrown by the wheel of a moving vehicle can shatter either an untreated lens or an impact-resistant lens. Wearers of sunglasses are cautioned to consider them as designed for protection from excessive light. The degree of protection from foreign bodies is no greater when wearing sunglasses than when the eyes are uncovered. ☞

## AWARDS AND HONORS

### *Legion of Merit*

RADM John W. Albrittain, MC, USN (now retired)  
RADM John P. Arthur, DC, USN (now retired)  
CAPT Emmett L. Van Landingham, Jr., MSC, USN (now retired)

### *Meritorious Service Medal*

RADM William C. Turville, MC, USN  
CAPT Edward D. Mateik, MSC, USN  
CAPT Albert J. Schwab, MSC, USN  
CDR Lewis E. Angelo, MSC, USN  
CDR George P. Kane, MSC, USN  
CDR J.C. Smout, MSC, USN

### *Joint Service Commendation Medal*

CAPT William G. Cumming, MSC, USN  
LCDR James C. Bond, MSC, USN

### *Navy Commendation Medal*

RADM George D. Selfridge, DC, USN  
LCDR Richard L. Boyle, MSC, USN  
HMCS Millard J. Gomez, USN  
HM1 William F. Wroda, USN ☞

## AMERICAN BOARD CERTIFICATIONS

### *American Board of Anesthesiology*

LCDR Jerry A. Perisho, MC, USN

### *American Board of Endodontics*

CAPT James E. Ainley, DC, USN

CDR Edward M. Osetek, DC, USN

### *American Board of Internal Medicine*

LCDR John D. Bibb Jr., MC, USNR

LCDR Clancy L. Cone, MC, USNR

CDR Michael F. Fornes, MC, USN

LT Joel Greenspan, MC, USNR

LCDR David B. Harvey, MC, USNR

LCDR Rafael J. Igartua, MC, USNR

LT Leland K. Krantz, MC, USNR

LCDR John Harold Masys, MC, USN

LCDR Martin J. McGreevy, MC, USNR

LCDR John E. McWhorter, MC, USNR

CDR Wood G. Van Valkenburgh, MC, USN

CAPT Eugene P. Walter, MC, USN

### *American Board of Oral Pathology*

CDR Benton E. Crawford, Jr., DC, USN

CDR John M. Foley, DC, USN

CDR Gerald L. Pierce, DC, USN

### *American Board of Oral Surgery*

CDR Lathe L. Bowen, DC, USN

CDR Matthew R. Cummings, DC, USN

CDR Alfred D. Loizeaux, DC, USN

CDR Ralph B. Maw, DC, USN

CDR George W. Oatis, Jr., DC, USN

CDR David J. Smith, DC, USN

CDR James E. Yeager, DC, USN

### *American Board of Orthopedic Surgery*

LCDR John H. True, MC, USNR

### *American Board of Otolaryngology*

LCDR James N. Endicott, MC, USNR

### *American Board of Pediatrics*

CDR Donald M. Robinson, MC, USN

### *American Board of Preventive Medicine in Aerospace Medicine*

CDR Robert P. Caudill, MC, USN

CDR Radcliffe J. Coyle, MC, USN

LCDR Michael D. Stenberg, MC, USN

### *American Board of Preventive Medicine in Occupational Medicine*

CDR Edward J. Sullivan, MC, USN

### *American Board of Prosthodontics*

CDR George A. Bloch, DC, USN

CDR Richard J. Grisius, DC, USN

LCDR Harry C. Mullins, DC, USN

LCDR John W. Porter, DC, USN

### *American Board of Radiology*

LCDR Jon H. Dodson, MC, USN

LCDR Leslie G. Werner, MC, USN

### *American Board of Radiology in Therapeutic Radiology*

LCDR Dennis R. Hill, MC, USNR

### *American Board of Surgery*

LCDR Nelson P. Davis, II, MC, USNR

CDR Dennis B. Goodman, MC, USN

LCDR Richard E. Pries, MC, USN

LCDR Garry L. Smith, MC, USNR

### *Conjoint American Board of Nuclear Medicine*

CDR Richard G. Drewyer, MC, USN

CDR John D. Marriott, MC, USN

## AMERICAN COLLEGE OF DENTISTS FELLOWSHIPS

At the recent meeting of the American College of Dentists in Houston, Tex., RADM R.G. Ziolkowski, DC, USNR-R; CAPT Roger H. Howard, DC, USN; CAPT Harry C. Pebley, DC, USN; CAPT Dean L. Johnson, DC, USN; and CAPT Elgene G. Mainous, DC, USN, were all awarded Fellowships in the College.

The American College of Dentists was organized in 1920. Through Fellowships, it recognized those who have contributed to the advancement of the profession and humanity. Its programs include seminars and workshops; it conducts studies in associated areas of interest, in dentistry and its service to the public. Fellowship in the College is by invitation. ☘



## ✠ In Memoriam ✠

*LCDR John X. Balog, MSC, USN (Ret.)* died on 12 Jul 1973 in Ashland, Ore. He was born in Shamford, Conn., on 5 Feb 1914, and enlisted in the Navy on 9 Oct 1931.

During the ensuing years LCDR Balog served at the Naval Training Station, Hampton Roads, Va. He attended the Hospital Corps School in Portsmouth, Va., and subsequently served at Nav Hosps Philadelphia and Canacao, P.I. In addition to serving at sea in USS *Black Hawk*, USS *Memphis*, and USS *Howard*, he served as a member of the staff at Headquarters, 14th Naval District, Pearl Harbor; at the Bureau of Medicine and Surgery, Wash., D.C.; and for the Commander Naval Forces, Japan. Appointed Warrant Officer on 1 Feb 1943, he was subsequently commissioned ENS in May 1943. On 1 Jan 1955 he was promoted to the rank of LCDR in the Navy Medical Service Corps.

LCDR Balog held the following decorations and medals: Silver Star with one bronze oak leaf cluster, Navy Commendation with combat "V," Good Conduct with three bronze stars, China Service, American Defense Service with one bronze star, American Campaign, Asiatic-Pacific Campaign with one bronze star, World War II Victory, National Defense Service, Philippine Defense with one bronze star, and the U.S. Army Meritorious Unit Commendation with one bronze star.

LCDR Balog is survived by his wife, Noreen; and three daughters, Dale, Denise, and Darlene. Mrs. Balog resides at 500 Emigrant Creek Road, Ashland, Ore. 97520.

*CAPT George Lloyd Calvy, MC, USN (Ret.)* died 2 Jun 1973 at Naval Hospital, Newport, R.I. He was born 20 May 1910 in Fond du Lac, Wisc. After receiving a BA degree (Medical Sciences) from the University of Wisconsin, CAPT Calvy earned his MD degree at Washington University School of Medicine, St. Louis, Mo., in 1937. After serving his internship at St. Louis City Hospital, he was commissioned a LTJG in the U.S. Navy Medical Corps in Jul 1938.

In Jul 1939 CAPT Calvy went to sea in the USS *Altair*, and in Dec of that same year he became Division Medical Officer for the Destroyer Division 70. He was subsequently transferred to the Naval Air Station, Pensacola, Fla., for a course in Flight Indoctrination and Aviation Medicine, leading to his designation as Flight Surgeon. In this capacity he served in the USS *Ranger* (CV-4), from 1940-1942; in the USS *Munda* (CVE-104) in 1944; and in the USS *Point Cruz* (CVE-119), from 1945-1947 as Senior Medical

Officer. Dr. Calvy subsequently gained postgraduate training in internal medicine, and was a Fellow at the Western Reserve University School of Medicine from 1948-1950. He was subsequently certified by the American Board of Internal Medicine, and on 1 Mar 1954 he was promoted to the rank of CAPT. During the period ending in Mar 1954, he served as Staff Medical Officer to the Commander, Military Sea Transportation Service, Western Pacific, for which he received a Letter of Commendation, with Ribbon and Metal Pendant, for meritorious service "in launching the successful functioning of a tuberculosis survey and in implementing an interservice anti-malaria program that previously defied control." In May 1954 he became Chief of Medicine at St. Albans Naval Hospital, N.Y., and in Mar 1959 he assumed command of the Naval Medical Field Research Laboratory at Camp Lejeune, N.C. On 1 Oct 1964 CAPT Calvy's name was placed on the Temporary Disability Retired List, and on 1 Mar 1969 his name was placed on the Permanent Retired List.

Dr. Calvy was a Diplomate of the American Board of Internal Medicine, and a Fellow of the American College of Physicians and the NY Academy of Medicine. He was a Senior Member of the American Federation for Clinical Research, an Associate of the Rockefeller Foundation (Research Project, 1942-1945), and a member of the NY Academy of Sciences. In addition to authoring 54 scientific papers on infectious disease, epidemiology, porphyria, and atherosclerosis, Dr. Calvy was awarded the Stitt Award in 1958 for his research in antibiotic medicine (staphylococcal pneumonia). Following his medical retirement from the U.S. Navy, Dr. Calvy worked as a medical consultant in private industry.

In addition to the Commendation Ribbon, CAPT Calvy held the following medals: American Defense Service Medal, American Campaign Medal, Asiatic-Pacific Campaign Medal, World War II Victory Medal, China Service Medal (extended), National Defense Service Medal, Korean Service Medal, and the United Nations Service Medal.

CAPT Calvy is survived by his wife, Mary; two children; a step-son; and three grandchildren. Mrs. Calvy resides at 2032 Indian Avenue, Portsmouth, R.I.

*CAPT Lewis G. Jordan, MC, USN (Ret.)* died 8 Sep 1973 in Arlington, Va., at the age of 81 years. A native of New York, he received his MD degree from the University and Bellevue Hospital Medical College of New York City, Class of 1917. Following



internship at Bellevue, St. Vincents and White Plains Hospitals in New York, he entered the Naval Service.

As a junior medical officer during World War I, CAPT Jordan served in the battleship USS *Rhode Island*, the USS *Calamaries*, USS *Seneca*, and the USS *Manning*. Prior to World War II, much of his sea service occurred in aircraft carriers, though he was not a flight surgeon. He served in USS *Lexington*; and he was Senior Medical Officer in the *Ranger* in 1936, and in the *Enterprise*, Jan 1940-Mar 1941.

While serving at the Naval Training Station in Norfolk, Va., Dr. Jordan was appointed to the rank of CAPT on 1 Jul 1941. He was subsequently involved in the conversion of the liner SS *Iroquois* to the hospital ship USS *Solace*, serving aboard *Solace* after her commissioning, and receiving a Letter of Commendation for outstanding service in *Solace* on 7 Dec 1941 at Pearl Harbor.

Dr. Jordan served on the Staff of the Commander Service Force, Pacific Fleet from Jun 1942 to Feb 1945, and subsequently was awarded the Legion of Merit for his medical logistic staff duty, and his service during the attack and capture of Kwajalein Island during that period. Following his subsequent assignment to the Materiel Division, Bureau of Medicine and Surgery, Naval Medical Supply Depot, Brooklyn, N.Y., he became Chief of this Division and Chairman of the Naval Medical Materiel Board in Apr 1946. In this capacity, and while later serving as Assistant Chief for Planning and Logistics at the Bureau (Nov 1948-May 1953), CAPT Jordan served as Chairman or Member of various, numerous committees concerned with medical procurement. After May 1953, he served in an advisory capacity as Special Assistant to the Assistant Chief for Planning and Logistics, BUMED. In Jul 1953, the Assistant Secretary of Defense (Health & Medical) awarded CAPT Jordan a Letter of Commendation for his foresight and effective planning which made it possible to stockpile blood derivatives, freed of infectiousness, thereby providing a large quantity of gamma globulin for preventing and modifying paralytic poliomyelitis in the children of the Nation.

After completing more than 36 years of continuous active service as a Navy medical officer, CAPT Jordan's name was placed upon the Retired List on 1 Mar 1954.

CAPT Jordan was a Diplomate of the American Board of Ophthalmology and Otolaryngology, and was also a Fellow of the American College of Surgeons. In addition to the Legion of Merit and two Letters of Commendation, he held numerous military awards and medals.

Funeral services, with simple military honors were conducted for the late CAPT Jordan at Arlington

National Cemetery in Arlington, Va. He is survived by one sister, Anna.

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*CAPT Clarence Cameron Kress, MC, USN (Ret.)* died 21 Sep 1973 in Richmond, Va., at the age of 89 years. He was born in Indianapolis, Ind., on 5 Feb 1884, and became an Assistant Surgeon in the U.S. Navy with the rank of LTJG on 18 Oct 1910.

CAPT Kress saw service in the USS *Celtic*, 1911-1914; USS *West Virginia* (renamed USS *Huntington*), 1916-1917; USS *Wisconsin*, 1918; USS *Vermont*, 1918-1919; USS *Chaumont*, 1922; and USS *Chicago*, 1922-1923. In Mar 1923 the Captain was assigned to the Naval Station Tutuila, Samoa, and in 1927-1929 he served again at sea in the USS *New Mexico*. He attended the University of Pennsylvania Graduate School of Medicine (1931-1932), and following a brief assignment at the Naval Shipyard in Philadelphia during 1934, he became a member of the staff at the Marine Barracks, Quantico, Va., with additional duty in the Fleet Marine Force.

On 1 Jul 1937, CAPT Kress's name was placed on the Retired List. While on the Retired List, he became Medical Inspector with the rank of CDR for temporary service, in Jan 1942; he subsequently became Medical Director with the rank of CAPT on the Retired List for temporary service, in Aug 1944. In the latter capacity, CAPT Kress served on the staff at Philadelphia Naval Hospital (1944-1945), and at the Naval Supply Depot, Pa. (1945-1946).

CAPT Kress held the Mexican Service Medal, World War I Victory Medal with Atlantic Fleet Clasp, American Defense Service Medal, World War II Victory Medal, and the American Campaign Medal.

He is survived by a daughter, Mrs. H.E. Gillespie, who resides at 1827 Grove Avenue in Richmond, Va.

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*CAPT Jerome Frost Smith, MC, USN (Ret.)* died 21 Sep 1973, in Richmond, Va. He was born on 16 Apr 1907 in San Diego, Calif. In 1930 he received his BA degree, and in 1934 his MD degree from Stanford University. He was commissioned a LTJG in the Medical Corps of the Naval Reserve in Jun 1934.

In Aug 1936 he was commissioned LT in the U.S. Navy Medical Corps, and became a medical officer at the Nav Hosp Mare Island. During the next 11 years CAPT Smith had alternating assignments as a medical officer at Nav Hosps San Diego, Bainbridge, and Philadelphia; during World War II he also served in USS *Chandeleur*, USS *Indianapolis*, and USS *Washington*. Having resigned his Regular commission in Jun 1947, he participated as a CDR in the Naval Reserve and

was assigned as medical officer at the Naval Reserve Training Center, San Diego.

On 28 Dec 1956, Dr. Smith was promoted to the rank of CAPT in the Navy Medical Corps, and he served as Chief of Medicine at Nav Hosp Camp Pendleton until Jul 1962. From Aug 1962 to Jun 1964, he was the Chief of Medicine and Chief of Research at Nav Hosp Chelsea, Mass. From Jul 1964-Jun 1966 he was the Executive Officer and Chief of Medicine at Nav Hosp Corpus Christi, Tex. In Jul 1966 CAPT Smith's name was placed on the Retired List.

CAPT Smith was a certified specialist in Internal Medicine, and a Fellow of the American College of Physicians. He held the Armed Forces Reserve Medal, the American Defense Service Medal with Fleet Clasp, American Campaign Medal, Asiatic-Pacific Campaign Medal with nine stars, World War II Victory Medal, Philippine Liberation Ribbon, and the National Defense Service Medal.

The late CAPT Smith is survived by his wife, Dorothy, who resides at 204 El Donado Dr., Richmond, Va.

*LCDR Wyman W. Wise, MSC, USN (Ret.)* died 20 Oct in Oceanside, Calif. He was born on 22 Nov 1907 in New Market, Iowa.

LCDR Wise's naval career began with recruit training at the Naval Training Center in San Diego, Calif., in 1929. He then attended Hospital Corps School at the Nav Hosp, San Diego, Calif., Jun 1929-Aug 1929. Subsequent assignments included Nav Hosps Philippines

(1929-1932), Great Lakes, Ill. (1932-1933), and Brooklyn, N.Y. (1934-1935). From 1935 to 1936 he served with the 4th Marine Division in Shanghai, China, and subsequently served in the USS *Tulsa* (1936-1937). From 1937-1940, he was a staff member at Nav Hosps Canacao, P.I., and Portsmouth, N.H.

Subsequent to commissioning as ENS in the U.S. Navy Medical Service Corps on 15 May 1943, LCDR Wise served as the Personnel Officer at Nav Hosp Bainbridge, Md. He undertook instruction at Princeton and Columbia Universities from Oct 1944 to Feb 1945, in Military Government, prior to several assignments as Personnel Officer that included duty at Okinawa (1945-1946), and Nav Hosps at Brooklyn, N.Y.; Charleston, S.C.; and Yokosuka, Japan. He served in the capacity of administrative officer at the Bureau of Medicine and Surgery, Wash., D.C., from 1954-1959. On 1 Jun 1953 he was promoted to the rank of LCDR, and his name was placed on the Retired List in May 1959.

LCDR Wise held the following medals: Good Conduct with three stars, American Defense Service with bronze star, American Campaign, Asiatic-Pacific Campaign with one star, Navy Occupation Service, World War II Victory, National Defense Service, and the Korean Service Medals.

Funeral services with full military honors were conducted for the late LCDR Wise on 26 Oct 1973 at the Arlington National Cemetery, Arlington, Va. He is survived by his wife, Helen, who resides at 3120 Morningside Drive, Oceanside, Calif. 92054. ☙

## NEW NAVAL HOSPITAL CAMP PENDLETON



Moving right along is construction of the new Naval Hospital at Camp Pendleton, Calif.

CAPT Frederick E. Jackson, MC, USN, Chief of Neurological Surgery and Chief of Research at the hospital, keeps us well informed. In the accompanying

photo which he provided, the new edifice appears in the left background. (New corpsmen's quarters occupy the right foreground.) The photo was taken in the late summer of 1973, and occupancy is projected for July, 1974. ☙

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NORTH POLE GREETINGS.—Dressed as Santa Claus, Chief Quartermaster Jack Patterson greeted CDR Alfred S. McLaren, USN (right), CO of the nuclear-powered submarine USS *Queenfish* (SSN-651), during the submarine's visit in 1970. (Courtesy of the Naval Photographic Center, Naval Station, Washington, D.C.)

U.S. NAVY MEDICINE